Intensive Care Coordination: Assessment and Intervention Tool

Notes

Green text in a `monospace` font indicates an action taken by the database system.

Clicking any item will record it in the system as *selected*.

Text in blue indicates a relatively new or enhanced nursing intervention.

Nursing Assessment and Intervention

Medical Condition

(including Awareness of Diagnosis)

"Patient/family verbalizes understanding of why patient has CCS?" `[yes/no]`

- Provide orientation to CCS. `[InfoBox opens with important highlights and talking points]`
- Send brochure
- Send SAR with card
- Send improved welcome letter, including reference to CCS website.
- Provide rights and responsibilities handout to patient/family.
- Orient to enhanced, family friendly CCS website
- Provide CCS contacts/phone numbers
- Provide patient/family a binder to keep reports/information.
- Refer to Family Resource Network (FRN).
- Other interventions
- Additional comments, if necessary `[pop-up free text]`
- Follow up with patient/family to reassess. `[pop-up calendar]`

"Patient/family verbalizes understanding of diagnosis?" `[yes/no]`

- Refer to CCS authorized provider
- Provide general information
- Refer to appropriate resources
- Other interventions
- Additional comments, if necessary `[pop-up free text]`
- Follow up with patient/family to reassess. `[pop-up calendar]`

"Patient receiving services at appropriate medical home?" `[yes/no]`

- Refer to available medical home (CHDP, etc)
- Refer to managed care or insurance plan for resources
- Refer to community provider/liaison
- Refer to health educator
- Refer to transition specialist
- Other interventions
- Additional comments, if necessary `[pop-up free text]`
- Follow up with patient/family to reassess. `[pop-up calendar]`

"Patient receiving care with appropriate specialist?" `[yes/no]`

- Refer to appropriate provider
- Provide education to family/patient re: importance of center care
- Provide education to family re: CCS paneling standards
- Other interventions
- Additional comments, if necessary `[pop-up free text]`
- Follow up with patient/family to reassess. `[pop-up calendar]`

"Patient/family verbalizes understanding of treatment plan?" [yes/no]

- Provide education to patient/family
- Refer to special care center/specialist
- Coordinate with appropriate provider as needed
- Initiate case conference, as needed
- Refer to CCS nutritionist
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient receiving care with other specialist(s)?" [yes/no]

- Discuss reasons behind specialty follow up
- Obtain information/medical reports
- Authorize specialist(s) as appropriate
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient/family aware of rights and responsibilities?" [yes/no]

- Inform of right to receive medical reports
- Inform of right to obtain second opinion
- Inform of right to obtain treatment plan in client's language
- Inform of right to appeal
- Inform of right of confidentiality
- Inform of right to select different specialist(s) or special care center, if available
- Instruct patient/family to notify specialist(s) of any changes
- Instruct patient/family to notify specialist(s) of all medications
- Instruct patient/family to keep all medical appointments or call to reschedule
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

Multiple Providers

"Patient/family verbalizes understanding of when to call PMD or specialist?" [yes/no]

- Provide education to patient/family re: which provider to contact for a specific need
- Offer updated contact information for each specialist including name of specific clinic contact person, as available
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient/family able to keep clinic appointments?" [yes/no]

- Assess how many specialty medical appointments missed, if any, by reviewing online systems and/or contacting clinic(s)
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient/family verbalizes barriers to clinic attendance?" [yes/no]

- Transportation-Refer to PST or SW
- Finances: Refer to SW
- Distance: Locate alternate clinic/center, if available
- Childcare Conflict: coordinate with clinic for more suitable appointment time
- SW referral as needed
- Work Conflict: coordinate for different clinic appointment time.
- Limited Family/Friends Support: SW referral as necessary

- Multiple Appointments/Multiple Clinics: coordinate with special care centers, consolidate appointments as able, inform center staff of family challenges
- Initiate case conference, as needed
- Family conference, as necessary
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"All medical providers are aware of each other's participation in care?" [yes/no]

- Contact providers and discuss.
- Mail/fax to each authorized provider, a copy of their own SAR
- Provide to patient/family copies of all patient's SARs
- Inform and educate re: systems of care
- Mail/fax to each authorized provider a letter listing all of client's SARs
- Assess for reliable contact person in each provider office
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

Multiple Vendors

"Patient/family verbalizes understanding of renewal process?" [yes/no]

- Review with patient/family which specialist to contact for new and refill prescriptions
- Instruct patient/family re: length of time necessary to reorder needed supplies/prescriptions to avoid running out
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient/family verbalizes difficulty in receiving services from multiple vendors?" [yes/no]

- Clarify names and contact info of all vendors
- Assess which services/supplies are rendered through each vendor
- Confirm SAR status
- Coordinate services/supplies of all vendors
- Identify and secure additional appropriate vendors as needed
- Initiate case conference, as necessary
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

Hospitalizations

"Patient/family verbalizes history of patient's hospitalization within past year?" [yes/no]

- Confirm number of recent hospitalizations via online hospital system, provider, or other
- Identify which hospitalizations appear to be related to CCS ME condition(s)
- Assess patient/family knowledge and understanding of reason for hospitalization(s)
- Determine if patient required readmission to hospital 30 days or less after preceding admission
- Assess number of ER visits
- Assess number of ER visits that resulted in an admission
- Assess patient/family perception of hospitalization course
- **Contact patient/family post ER visit (optimally within 72 hours) to discuss experience and reinforce teaching**
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient/family verbalizes comfort and understanding of patient discharge?" [yes/no]

- Contact patient/family post discharge(optimally within 72 hours) to discuss experience, review discharge instructions, and reinforce teaching
- Refer patient/family to specialist(s) as necessary
- Assess for any medical follow up appointments as needed
- Assist in establishing medical follow up appointment(s), if necessary
- Refer patient/family to pharmacist(s) as needed
- Refer patient/family to DME vendor, as necessary
- Refer patient/family to medical home, as needed
- Refer patient/family to community resources, as necessary
- Refer patient/family to Home Health Agency, as necessary
- Contact/coordinate with appropriate providers, vendors, and/or community partners, as needed
- Coordinate patient/family education regarding home equipment prior to discharge from hospital
- Initiate case conference, as necessary
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

DME/Supplies/Pharmaceuticals

"Patient/family verbalizes knowledge of DME/supplies in home?" [yes/no]

- Assess which equipment/supplies in home and length of time in place
- Provide vendor contact numbers for renewal and repairs, as appropriate
- Assess knowledge level for patient/family use of DME/equipment
- Contact vendor to clarify what has been provided and any education needed
- Coordinate additional patient/family education with special care center, vendor or MTU for new equipment, as needed
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient/family verbalizes difficulty in obtaining and/or renewing DME/Supplies?" [yes/no]

- Assess baseline knowledge regarding supplies/DME
- Orient patient/family to process of obtaining needed supplies/DME
- Contact vendor to discuss
- Contact provider to discuss
- If need is urgent, direct to medical provider, urgent care or ER
- Educate patient/family re: need for ongoing medical assessment for continued authorizations of supplies/DME/prescriptions
- Refer to CCS nutritionist, as needed
- Refer to therapy case manager, as needed
- Initiate case conference, as necessary
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient has been prescribed medication for CCS eligible condition?" [yes/no]

- Inquire if medications are present in home
- Refer to appropriate pharmacy, as necessary
- Assess patient/family knowledge of prescribed medication and side effects
- Orient patient/family to renewal process
- Remind patient/family of need to bring list of medication(s) to each medical appointment
- Educate patient/family regarding when to contact provider
- Orient patient/family re: SAR cards
- Initiate case conference, as needed
- Other interventions

- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

Medical Therapy Unit (MTU):

"Patient is open to MTU?" [yes/no]

- Educate patient/family regarding role of administrative office versus MTU
- Provide appropriate contact person(s) and phone number for MTU
- Coordinate with specific MTU nurse liaison
- Discuss case with MTU staff, as appropriate
- Refer to therapy case manager, as necessary. [InfoBox opens with instructions on when appropriate to refer.]
- Refer to DME coordinator, as appropriate. [InfoBox opens with instructions on when appropriate to refer.]
- Initiate case conference, as needed
- Initiate family conference, as necessary
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

Coordination Issues:

"Patient/family verbalizes involvement with other agencies and has appropriate contact information?" [yes/no]

- Home health agencies
  - Premier [pop-up free text]
  - Maxim [pop-up free text]
  - ResCare [pop-up free text]
  - My Best Homecare [pop-up free text]
  - John Muir Homecare [pop-up free text]
  - Other [pop-up free text]
- EPSDT/In Home Operations (IHO) [pop-up free text]
- Developmental disabilities/community agencies
  - Regional Center [pop-up free text]
  - FRN (Family Resource Network) [pop-up free text]
  - Vocational Rehab [pop-up free text]
  - Ed Roberts [pop-up free text]
  - Other [pop-up free text]
- Schools/IEP [pop-up free text]
- Early intervention programs
  - Special Start [pop-up free text]
  - BIH (Black Infant Health) [pop-up free text]
  - NFP (Neonatal Follow Up Program) [pop-up free text]
  - Help Me Grow [pop-up free text]
  - Other [pop-up free text]
- Social services agencies [pop-up free text]
- Recreational services
  - BORP (Bay Area Outreach and Recreation Program) [pop-up free text]
  - Special Camps [pop-up free text]
  - Other [pop-up free text]
- Behavioral health [pop-up free text]
- Respite care
  - IHSS (In Home Supportive Services) [pop-up free text]
  - George Mark [pop-up free text]
  - Palliative Care [pop-up free text]
  - Other [pop-up free text]
- Other agency or program [pop-up free text]
- Additional comments, if necessary [pop-up free text]

- Follow up with patient/family to reassess. [pop-up calendar]

"Patient/family verbalizes interest in additional resources?" [yes/no]

- Refer to appropriate outside agency [pop-up mandatory with fields for agency name, contact person, tel]
- Refer to appropriate community resource [pop-up free text]
- Refer to SW III
- Refer to transition specialist
- Refer to CCS nutritionist
- Refer to special care center nutritionist
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient/family requests assistance in coordinating care for patient?" [yes/no]

- Educate patient/family regarding role of various agencies
- Contact appropriate agencies to discuss
- Contact providers to discuss
- Encourage and facilitate communication between all involved agencies and providers
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient/family verbalizes difficulty with coordination of benefits between insurances?" [yes/no]

- Provide patient/family with general overview of CCS vs private insurance
- Refer to SW III, as appropriate
- Establish contact with private insurance liaison(s), as appropriate
- Coordinate and negotiate needed services and/or supplies with insurance companies and vendors
- Consult with CCS Administration and/or medical consultants, as needed
- Initiate case conference, as needed
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient requiring assistance with transition services?" [yes/no]

- Refer to PST to send appropriate transition letter and/or packet
- Contact patient/family to discuss transition needs
- Discuss transition to adult provider(s) with Special Care Center RN/MD/SW staff
- **Assess for any outstanding CCS eligible medical treatment that should be completed prior to patient's 21st birthday**
- Refer to transition specialist
- Refer to community partners, as necessary
- Initiate transition case conference, as needed
- Initiate family conference, as requested
- Refer to SW III for guidance with insurance issues
- Provide patient/family with education on self-advocacy and independence, as appropriate
- Coordinate/assist in establishing communication between pediatric providers and adult providers, as needed
- Other interventions
- Additional comments, if necessary [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

Social Work Assessment and Intervention

Assessment [yes/no]

- Sensitive Services
- Domestic violence
  - Referred to Domestic Violence Resource [pop-up free text]
- Conservatorship
  - Refer to Legal Aid [pop-up free text]
  - Refer to Public Guardian [pop-up free text]
  - Refer to Family Resource Network
  - Other resources [pop-up free text]
- Housing
  - Refer to Oakland Housing Authority for Non-Elderly Disabled Voucher (NED) [pop-up free text]
  - Refer to family shelter
  - Other housing resources [pop-up free text]
- Food stability
  - Refer to WIC
  - Refer to Food Bank
  - Other food resources [pop-up free text]
- School
  - Refer to MTP
  - Refer to CCS SELPA liaison
  - Other resources [pop-up free text]
- Peer issues (bullying)
  - Refer to Through the Looking Glass
  - Consult with MTP [pop-up free text]
  - Consult with school [pop-up free text]
  - Conference with caregiver [pop-up free text]

Mental Health Referral [yes/no]

- Family counseling
  - Refer to BHCS
  - Refer to PCP
  - Refer to SCC out-patient
  - Refer to Through the Looking Glass
  - Refer to Family Resource Network
  - Refer to Family Navigator
  - Other resources [pop-up free text]
- Individual counseling
  - Refer to BHCS
  - Refer to PCP
  - Refer to SCC out-patient
  - Refer to Through the Looking Glass
  - Refer to Family Resource Network
  - Refer to Family Navigator
  - Other resources [pop-up free text]
    - Follow up [pop-up calendar]
    - Follow up action
    - appointment made [pop-up calendar]
    - appointment kept
    - other [pop-up free text]
- Special Care Center (SCC)
  - Refer to SCC for psychosocial intervention [pop-up free text]
  - Refer to SCC for health education [pop-up free text]

Transition [yes/no]

- Independent living
  - Refer to Center for Independent Living

    - Consult with Social Services Agency [pop-up free text]
- Transition planning
    - Refer to Transition Program Specialist [pop-up free text]
    - Refer to MSW [pop-up free text]
    - Insurance
    - Medi-Cal
    - SSI
    - School [pop-up free text]
    - Refer to Community Clinic [pop-up free text]
    - Refer to Community College/University Disabled Student Services [pop-up free text]
    - Refer to Vocational Rehab [pop-up free text]

Foster Care and Child Custody [yes/no]

- Contact with Child Welfare Worker (CWW) [pop-up has fields for name, tel, and free text]
- Legal Guardian/Foster Parent [pop-up has fields for name, tel, address, and free text]
- Medical Decision-Making
    - Primary [pop-up has fields for name, tel, address, and free text]
    - Secondary [pop-up has fields for name, tel, address, and free text]

Mandated Reporting [yes/no]

- Child Protective Services [yes/no]
    - Non-accidental injury [pop-up has fields for date report made, time report made, and free text]
    - Neglect [pop-up has fields for date report made, time report made, and free text]
    - Other [pop-up has fields for date report made, time report made, and free text]
- Adult Protective Services [yes/no]
    - Non-accidental injury [pop-up has fields for date report made, time report made, and free text]
    - Neglect [pop-up has fields for date report made, time report made, and free text]
    - Other [pop-up has fields for date report made, time report made, and free text]

Case Conference [yes/no]

- Conference with family and NCM [pop-up free text]
    - Financial eligibility interview [pop-up free text]
- Conference with hospital Social Worker
    - CHO
    - LPCH
    - UCSF
    - ACMC
    - Other [pop-up free text]
- Conference with CCS MSWs [pop-up free text]
- Conference with and or referral to CCS Transportation Coordinator
- Conference with NCM [pop-up free text]
- Conference with Family Navigator [pop-up free text]

MTP [yes/no]

- Coordinate FE with MTU site
- Refer to Family Resource Network [pop-up free text]
- Conference with MTU [pop-up free text]
- On-Site MTU visit [pop-up free text]

Diagnosis [yes/no]

- Refer to CCS Medical Consultant [pop-up free text]
- Conference with CCS Supervisor and NCM [pop-up free text]
- Conference with CCS Supervisor and MRT Supervisor [pop-up free text]

Transportation [yes/no]

- Refer to Patient Services Technician [pop-up free text, labeled “PST Notes”]
    - Transportation reason
        - Medical appointment
        - Procedure

        - Surgery
        - MTP
    - Transportation Type
        - Taxi sedan
        - Wheelchair van
    - Itinerary
        - Date [pop-up calendar]
        - Time [time pop-up]
        - From Location Name [pop-up free text]
        - Address [pop-up free text]
        - To Location Name [pop-up free text]
        - Address [pop-up free text]
        - Return Trip Pick Up Time [time pop-up]

Maintenance [yes/no]

- Refer to MSW [pop-up free text, labeled "MSW Notes"]
- Maintenance type
    - Lodging
        - Address [pop-up free text]
        - From [pop-up calendar]
        - To [pop-up calendar]
        - Cost per day [pop-up money]
    - Food Vouchers
        - From [pop-up calendar]
        - To [pop-up calendar]
        - Cost per day [pop-up money]

Medi-Cal/Covered California

- Refer to Medi-Cal
    - Eligibility Worker [pop-up box has fields for worker name, tel, and free text]
    - Application date [pop-up calendar]
- Covered California
    - Refer to PEU
        - Insurance name [pop-up free text]
        - Insurance type [pop-up box has radio buttons for Bronze, Silver, and Gold, and a section for free text]
- Refer to Clearinghouse for Medi-Cal appointment
- Other [pop-up free text]

Regional Center of the East Bay (RCEB) [yes/no]

- Refer to RCEB
- RCEB Case conference [pop-up free text]
- RCEB Case manager [pop-up has fields for case manager name, phone number, and a section for free text]

Immigration

- Refer to IIBA (International Institute of the Bay Area) for immigration status protection, applying for DACA (Deferred Action for Childhood Arrivals) status. [pop-up free text]
- Other resources [pop-up free text]

Billing

- Investigate medical billing to clients [pop-up free text]
- Investigate collection agency actions [pop-up free text]
- Conference with CCS Billing [pop-up free text]
- Consult with Billing Supervisor [pop-up free text]

Miscellaneous Psychosocial Intervention [pop-up free text]

Miscellaneous Financial Eligibility Issues [pop-up free text]

Other miscellaneous [pop-up free text]

Transition Assessment and Intervention

Medical/ Health Care Transition

"Patient is 17 to 20 years old (or younger with an expressed transition need)?" [yes / no]

- Refer to PST to send appropriate transition letter and/or packet
- Contact patient/family to discuss transition needs [pop-up free text]
- If MTU client, discuss with unit supervisor or therapist [InfoBox opens, options to select: Glankler, West Oakland, Cesar Chavez, Valley, Bay]
- Assess for any outstanding CCS eligible medical treatment that should be completed prior to patient's 21st birthday [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient needs adult doctor(s) and/or medical home referral, for services after age 21?" [yes / no]

- PCP-Refer to local Community Clinic resources: CHCN/ AHS [InfoBox opens, options to select: CHCN: La Clinica de La Raza, Tri-City Health Center, Lifelong Medical Care, Tiburcio Vasquez, Asian Health Center, Native American Health Center, West Oakland Health Council. AHS: Eastmont Wellness, Hayward/Winton Wellness, Newark Wellness, Highland Wellness]
- Discuss transition to adult providers & available physicians with pediatric primary care or specialty provider [pop-up free text]
- Refer to Medi-Cal managed care plan
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient needs adult rehab referral?" [yes / no]

- Refer to Therapy Case Manager
- Discuss Alta Bates Disabled Community Health Center Services & Referral Process. [pop-up free text]
- Discuss Fairmont Outpatient Services & Referral Process. [pop-up free text]
- Consult with patient current providers [pop-up free text]

"Patient needs adult Health insurance referral?" [yes / no]

- Refer to SW III for guidance with insurance issues
- Refer to community clinic Eligibility/ Member Services Dept. [pop-up free text]
- Refer to Social Services Office
- Refer to Covered California Resources [InfoBox opens: http://www.coveredca.com/enrollment-assistance/]
- Refer to GHPP
- Follow up with patient/family to reassess. [pop-up calendar]

Psychosocial & Environmental Transition

"Patient/caregiver needs transition & health self-management education?" [yes / no]

- Discuss process of transition to adult provider(s) [pop-up free text]
- Provide & review Transition Healthcare Skills Checklist
- Provide patient/family with education, as appropriate [pop-up free text]
- Referral to Public Health Nursing for education & support
- Referral to Alameda Alliance for Health case management, for education & support
- Consult with Special Care Center providers [pop-up free text]
- Refer to family navigator
- Follow up with patient/family to reassess. [pop-up calendar]

"Patient/caregiver needs transition psycho-social support?" [yes / no]

- Phone-based counseling support [pop-up free text]
- Office/ MTU based- counseling support [pop-up free text]

- Referral to Through the Looking Glass
- Consult with Special Care Center providers [pop-up free text]
- Consult with other Case Management Staff [InfoBox opens: RCEB, La Familia, ACMHS, PHN, School-based: (fill in)_____, other services (fill in)_____]
- Refer to family navigator
- Refer to other counseling support [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

"Family/ caregiver(s) need legal decision making/ conservatorship information?" [yes / no]

- Provide Durable Power of Attorney vs. Conservatorship info
- Referral to Probate Court
- Legal aid resource referral [InfoBox opens, options to select: Bay Legal Aid, East Bay Community Law Center, Alameda County Bar Association, other legal aid resource (fill in)____]
- Disability Rights California/ Regional Center Clients' Rights Office Referral
- Family Resource Network
- Follow up with patient/family to reassess. [pop-up calendar]

- **"Patient needs independent living skill/ disability support program referral?"** [yes / no]
  - Center for Independent Living, Berkeley (CIL)
  - Community Resources for Independent Living (CRIL)
  - Community Care Transitions (East Bay Innovations)
  - Spinal Cord Injury Peer Support Group
  - Consult with Regional Center of the East Bay/other Developmental Disability services [InfoBox opens, select & fill in: Supported Living:_____, Day Program:____, School:_____]
  - Other Independent Living Skill Services referral [pop-up free text]
  - Follow up with patient/family to reassess. [pop-up calendar]

- **"Patient/caregiver needs transitional housing/ Living Situation Referral?"** [yes / no]
- [InfoBox opens second, select: Foster Care Y_N_; Juvenile Justice Y_N_; Homeless Y_N_]
  - First Place for Youth
  - BAYC/ Sunny Hills Program
  - Building Opportunities for Self Sufficiency
  - ABODE Family Services
  - Covenant House
  - DreamCatcher Youth Shelter
  - Healthcare for the Homeless
  - Criminal Justice Mental Health Case Managmenet
  - 211/ Eden I&R
  - Other Transitional Program Referral[pop-up free text]
  - Follow up with patient/family to reassess. [pop-up calendar]

- **"Patient/caregiver needs transportation support/ program referral?"** [yes / no]
  - Travel Training [InfoBox opens, select: Community Resources for Independent Living, Center for Independent Living Mobility Matters, Bay Area Outreach Recreation Program, Through the Looking Glass, Lions Center for the Bind, City of Alameda, Tri-City, Livermore Amador Valley]
  - ADA Paratransit [InfoBox opens, select: East Bay Paratransit, WHEELS Dial-a-Ride, Union City]
  - Local Paratransit Supplement [InfoBox opens-fill in: City:_____]
  - Paratransit voucher program (Alameda Alliance)
  - Adaptive Driving Resources
  - Disabled Diver Placard
  - CCS Transportation PST
  - Follow up with patient/family to reassess. [pop-up calendar]
-
- **"Patient needs school/ vocational program referral?"** [yes / no]

- Community College Disabled Student Program[InfoBox opens, select: Laney, Chabot, Ohlone, Las Positas, Berkeley City College, Other (fill in):_____]
- Department of Rehabilitation
- Job Corps
- Local Vocational Programs [InfoBox opens, select: EMT Corps, Civicorps, Youth Employment Partnership, Pivot Point, other program:_____]
- Alameda County Career Centers
- California School of the Blind
- Developmental Disability Resources [InfoBox opens, select: RCEB, EBI/Project SEARCH, CP Center, Clausen House, other program (fill in):___]
- Follow up with patient/family to reassess. [pop-up calendar]

- **"Patient needs social/ recreational/ leadership program referral(s)?"** [yes / no]
  - Center for Independent Living Berkeley Young Independent People
  - Community Resources for Independent Living Hayward Disability Action Network Youth
  - Bay Area Outreach Recreation Program (BORP)
  - Special Olympics
  - Special Needs Aquatics Porgram (SNAP)
  - CCS Young Adult Advisory Council
  - National Spinal Cord Injury Peer Support Group
  - Creative Growth Arts Program
  - Camps for youth with Disabilities [InfoBox opens, select: Easter Seals Camp Harmon, Ability First, Other Camp (fill in):____]
  - Other Agency Referral[pop-up free text]
  - Follow up with patient/family to reassess. [pop-up calendar]

General Social Service/Young Adult Service Transition

- **"Patient needs income/ financial program referral?"** [yes / no]
  - SSI/ Social Security
  - IHSS
  - CalWORKS
  - Refugee Assistance
  - SparkPoint Centers (planning)
  - Community Trust Loan (planning)
  - Disability Benefits Counseling [InfoBox opens, select: Center for Independent Living Berkeley, Community Resources for Independent Living, Disability Benefits 101, YO! Disabled & Proud]
  - Other financial services [pop-up free text]
  - Follow up with patient/family to reassess. [pop-up calendar]

- **"Patient needs immigration support referral?"** [yes / no]
  - International Institute of the Bay Area
  - Deferred Action for Childhood Arrivals (DACA) Loan Program (Community Trust)
  - East Bay Community Law
  - East Bay Sanctuary
  - Catholic Charities of the East Bay
  - Other immigrant support services [pop-up free text]
  - Follow up with patient/family to reassess. [pop-up calendar]

- **"Patient needs sexual/partnership health & safety information referral?"** [yes / no]
  - Planned Parenthood [InfoBox opens, select: Shasta-Pacific Disability Program? Y_N_]
  - Teen power / Full power
  - Connect University
  - Outreach Literature: Sexual Health & Safety for Young People with Disabilities [pop-up free text]

- Dating & Sexual Violence Hotlines [InfoBox opens, select: Family Violence Law Center 1-800-947-8301 **National Dating Abuse Hotline**: 1-866-331-9474; 1-866-331-8453 (TTY) **National Domestic Violence Hotline**: 1-800-799-SAFE; **Alameda County Hotlines:** A Safe Place: 510-536-7233, Family Violence Law Center: 1-**800-947-8301**, SAVE: 510-794-6055 Tri-Valley Haven: 1-800-884-8119)]
- Other support services [pop-up free text]
- Follow up with patient/family to reassess. [pop-up calendar]

- **"Patient needs parenting/pregnancy support referral?"** [yes / no]
  - Improving Pregnancy Outcomes Program (IPOP)
  - Public Health Nursing (PHN)
  - Black Infant Health
  - Fatherhood Program
  - BANANAS Childcare referrals & support
  - Brighter Beginnings
  - Clinic-based parent support group [InfoBox opens, select La Clinica de la Raza, Native American, Other Clinic:___]
  - Other Parent Support Services [pop-up free text]
  - Follow up with patient/family to reassess. [pop-up calendar]

  "Patient needs trauma specific support referral(s)?"
  - Assess current safety [pop-up free text]
  - Youth Uprising
  - Youth ALIVE!
  - California Youth Outreach (OCYO)
  - Behavioral Health Care Services Transition Age Youth (TAY) Program
  - Catholic Charities of the East Bay
  - Family Justice Center
  - DreamCatcher Youth Services
  - Refer to other trauma-specific program(s) [pop-up free text]
  - Follow up with patient/family to reassess. [pop-up calendar]

"Does patient/ caregiver have other transition questions or concerns?" (Y/N) [pop-up free text]