**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **BIRTHDATE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CCS#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  **16 yrs. ATC date**\_\_\_\_\_\_\_\_\_\_ | **Primary Care Physician/Medical Home**  | **Other case managing agency (s) Therapist** |
| Name: Address:Dentist: | (County Name): IHO: IEP: School District:  | yes | no | Caseworker:\_\_\_\_\_\_\_\_\_\_\_\_Attendance:\_\_\_\_\_\_\_\_\_\_\_Residence:\_\_\_\_\_\_\_\_\_\_\_\_ |
| yes | no |
| yes | no |
| yes | no |
|  |  |
| **Healthcare Coverage Current Authorizations**  |
| * Medi-Cal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* CCS Only \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Healthy Families
* Private Insurance: coverage type:

 HMO\_\_\_\_\_\_\_\_ PPO\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_* No insurance
 | Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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|  **18 yrs. ATC date**\_\_\_\_\_\_\_\_\_\_ | **Primary Care Physician/Medical Home**  | **Other case managing agency (s) Therapist** |
| Name: Address:Dentist: | (County Name): IHO: IEP: School District:  | yes | no | Caseworker:\_\_\_\_\_\_\_\_\_\_\_\_Attendance:\_\_\_\_\_\_\_\_\_\_\_Residence:\_\_\_\_\_\_\_\_\_\_\_\_ |
| yes | no |
| yes | no |
| yes | no |
|  |  |
| **Healthcare Coverage Current Authorizations**  |
| * Medi-Cal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* CCS Only \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Healthy Families
* Private Insurance: coverage type:

 HMO\_\_\_\_\_\_\_\_ PPO\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_* No insurance
 | Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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|  **20 yrs. ATC date**\_\_\_\_\_\_\_\_\_\_ | **Primary Care Physician/Medical Home**  | **Other case managing agency (s) Therapist** |
| Name: Address:Dentist: | (County Name): IHO: IEP: School District:  | yes | no | Caseworker:\_\_\_\_\_\_\_\_\_\_\_\_Attendance:\_\_\_\_\_\_\_\_\_\_\_Residence:\_\_\_\_\_\_\_\_\_\_\_\_ |
| yes | no |
| yes | no |
| yes | no |
|  |  |
| **Healthcare Coverage Current Authorizations**  |
| * Medi-Cal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* CCS Only \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Healthy Families
* Private Insurance: coverage type:

 HMO\_\_\_\_\_\_\_\_ PPO\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_* No insurance
 | Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Medical Services**  | **16 yrs.** | **18 yrs.** | **20 yrs.** |
| Medical Specialists currently involved:  Orthopedist  Neuro  GI  Pulmon  Opthalm  Urol  Genetics  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | yes | no | yes | no | yes | no |
| Will current specialists continue care after discharge from CCS program and accept patient’s mode of funding? | yes | no | yes | no | yes | no |
| Patient/caregiver have provided signed consent for release of latest Medical Therapy Conference dictation, therapy assessment/plan and all x-rays from unit (final transition) | yes | no | yes | no | yes | no |
| **Medical Home/Primary Care Physician/Medical Therapy Conference** |  |  |  |  |  |  |
| Do you have a current Medical Home or PCP who can provide carefollowing your discharge from CCS regarding important needs such asoverall medical care, supplies and medication? | yes | no | yes | no | yes | no |
| Behavior/personality/attitude changes/concerns noted and referred to Social Work, Medical Home or PCP for follow up as needed. | yes | no | yes | no | yes | no |
| Sex education (sexuality, birth control, etc.): referral to Medical Home orPCP for follow up as needed. | yes | no | yes | no | yes | no |
| Substance abuse: referral to Medical Home or PCP for follow up asneeded. | yes | no | yes | no | yes | no |
| **General Equipment Information Therapist** | **16 yrs.** | **18 yrs.** | **20 yrs.** |
| Home visit completed if needed | yes | no | yes | no | yes | no |
| Patient has braces or splints: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | yes | no | yes | no | yes | no |
| Patient has DME vendor and Orthotist information | yes | no | yes | no | yes | no |
| **Durable Medical Equipment – Rehab Therapist Purchase Date** | **16 yrs.** | **18 yrs.** | **20 yrs.** |
| Wheelchair: manual |  |  | yes | no | yes | no | yes | no |
| Wheelchair: power |  |  | yes | no | yes | no | yes | no |
| Walker/crutches |  |  | yes | no | yes | no | yes | no |
| Braces |  |  | yes | no | yes | no | yes | no |
| Toileting equipment |  |  | yes | no | yes | no | yes | no |
| Bath equipment |  |  | yes | no | yes | no | yes | no |
| ADL equipment (e.g., dressing, grooming) |  |  | yes | no | yes | no | yes | no |
| Feeding equipment |  |  | yes | no | yes | no | yes | no |
| Communication device |  |  | yes | no | yes | no | yes | no |
| Hospital bed |  |  | yes | no | yes | no | yes | no |
| Ramps |  |  | yes | no | yes | no | yes | no |
| Lift |  |  | yes | no | yes | no | yes | no |
| **Durable Medical Equipment – Medical Purchase Date** | **16 yrs.** | **18 yrs.** | **20 yrs.** |
| Ventilator |  |  | yes | no | yes | no | yes | no |
| O2 Supplies |  |  | yes | no | yes | no | yes | no |
| Apnea Monitor |  |  | yes | no | yes | no | yes | no |
| Trach. Supplies |  |  | yes | no | yes | no | yes | no |
| **Other:** |  |  | yes | no | yes | no | yes | no |
|  |  |  | yes | no | yes | no | yes | no |
|  |  |  | yes | no | yes | no | yes | no |

**Indicate N/A if item is not applicable to patient**

|  |  |  |  |
| --- | --- | --- | --- |
| **Funding Social Worker** | **16 yrs.** | **18 yrs.** | **20 yrs.** |
| Patient has been advised to apply for SSI | yes | no | yes | no | yes | no |
| If patient does not qualify for SSI, alternative means of funding and/or coverage by certain community agency’s (e.g., Regional Center, Charities) services have been discussed for expenses such as medical services, supplies, equipment and equipment repairs | yes | no | yes | no | yes | no |
| **Resources Social Worker** | **16 yrs.** | **18 yrs.** | **20 yrs.** |
| **Does family need help or have questions about:** |  |  |  |
| Guardianship/Conservatorship | yes | no | yes | no | yes | no |
| Living Situation/Respite care | yes | no | yes | no | yes | no |
| Mental Health | yes | no | yes | no | yes | no |
| In-Home Supportive Services, (IHSS), In Home Operations (IHO) | yes | no | yes | no | yes | no |
| Recreational/Social activities | yes | no | yes | no | yes | no |
| Transportation Resources | yes | no | yes | no | yes | no |

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| **MTP use only** |
| **Age 16**Date: | **Participant**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nurse Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Information provided by: |
| **MTP use only** |
| **Age 18**Date: | **Participant**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nurse Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Information provided by: |
| **MTP use only** |
| **Age 20**Date: | **Participant**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nurse Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Information provided by: |