**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 |
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| **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 care  following your discharge from CCS regarding important needs such as  overall 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 or  PCP for follow up as needed. | | | yes | | no | yes | | no | | yes | no |
| Substance abuse: referral to Medical Home or PCP for follow up as  needed. | | | 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**

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| **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: |