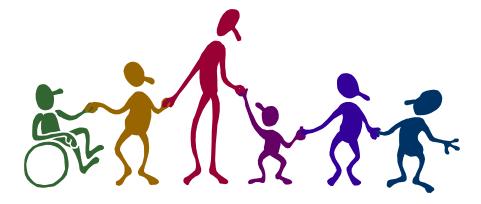


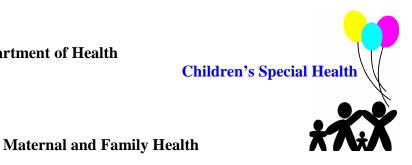
### **A Family Centered Care Coordination Notebook**



**Presented by:** 



Wyoming Department of Health





Feel free to make copies of any pages in this book!

#### ACKNOWLEDGEMENTS

Special thanks to the following people whose help made **Packaging Wisdom** possible:

#### \*\*\*\*\*

The many families of children with special healthcare needs in Wyoming for sharing your experiences to determine what should be in this book.

#### \*\*\*\*

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Wyoming Support Network – Carla S. Jackson



#### Please direct any comments, suggestions or questions to:

<u>Children's Special Health</u> Crystal Swires, Admin. Specialist 6101 N. Yellowstone Rd., Suite 420 Cheyenne, WY 82002 Phone: 800-438-5795 Fax: 307-777-7215 E-mail: <u>crystal.swires@health.wyo.gov</u>

This notebook has been thoughtfully put together for your convenience of use. Below are some suggestions.

#### Follow these steps to set up and/or make changes to your child's notebook:

#### **Step 1: Gather information**

Gather any health information about your child; this may include reports from recent doctor's visits, recent summary of a hospital stay, this year's school plan (IEP), test results, or informational pamphlets.

#### Step 2: Look through the pages of the notebook

Which of these pages could help you keep track of information about your child's health or care? Choose the pages you like. Print copies of any that you think you will use. Packaging Wisdom pages are available through the internet at <a href="http://wdh.state.wy.us/familyhealth/csh/index.html">http://wdh.state.wy.us/familyhealth/csh/index.html</a>, choose Packaging Wisdom.

## Step 3: Decide which information about your child is most important to keep in the notebook

What information do you look up often? What information do people caring for your child need?

#### Step 4: Put the notebook together

Everyone has a different way of organizing information. The goal of this notebook is to make finding the information easier. We have provided the "tools", now it is up to you to design the notebook in the most efficient way, thus allowing easier access to your child's health information and care coordination.

### YOU ARE THE EXPERT. YOU KNOW YOUR CHILD BETTER THAN ANYONE ELSE!

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### **Introduction:**

#### What is Packaging Wisdom Notebook?

Packaging Wisdom is an organizational tool for families who have children with special healthcare needs and/or disabilities. This notebook has been designed for families living in Wyoming.

#### How can Packaging Wisdom help you?

In caring for your child with special healthcare needs and/or disabilities, you may get information and paperwork from many sources. Packaging Wisdom helps organize this information in one central location. This notebook will make it easier for you to find and share information with others who are a part of your child's care coordination.

#### Use Packaging Wisdom to:

- Track changes in your child's medications and/or treatments
- Contact information for healthcare providers and community organizations
- Prepare for appointments
- File information about your child's health history
- Share new information with your child's primary care physician, public health nurse, school nurse, daycare staff, and others who provide care for your child
- Training for any person(s) who will be caring for your child
- Transitional planning
- Family and child history in case of emergency

#### Helpful hints for using Packaging Wisdom

- Store Packaging Wisdom in a safe, easy to find location. This will help you and anyone who needs information in the event you are not there
- Add new information to the notebook whenever there is a change in your child's condition, treatment, medication, provider, etc.
- We recommend taking Packaging Wisdom with you to appointments and/or hospital visits, this way any information will be ready and available

We hope this notebook will provide a sense of ease for you in maintaining information about your child.

## **Child's Personal Information**

	Middle:	Last Name:	
Nickname:	Date of Birth: /	/ Se	x: M F
Street Address:			
	rent than above):		
City:	State:	Zip Code	:
Phone: ()			
Color of Eyes:	Color of Hair:	Child's R	ace:
*****	******	******	*****
Primary Disability <u>:</u>			
Other disabilities:			
******	******	********	******
	******		
Primary Language:			
Primary Language <u>:</u> Primary Means of Comn			
Primary Language: Primary Means of Comn Wheelchair? Y N	nunication <u>:</u> Leg Braces? Y		
Primary Language: Primary Means of Comn Wheelchair? Y N Hearing? Excellent G	nunication <u>:</u> Leg Braces? Y pod Fair Poor		
Primary Language <u>:</u> Primary Means of Comn	<b>Leg Braces?</b> Y Dod Fair Poor Dod Fair Poor	N Walks?	
Primary Language:         Primary Means of Comm         Wheelchair? Y N         Hearing? Excellent         Go         Sight?         Excellent         Go         Handedness of Child?	<b>Leg Braces?</b> Y Dood Fair Poor Dood Fair Poor Right Left	N Walks?	
Primary Language: Primary Means of Comn Wheelchair? Y N Hearing? Excellent Go Sight? Excellent Go	<b>Leg Braces?</b> Y Dod Fair Poor Dod Fair Poor Right Left <b>nd directions?</b> Y N	N Walks?	

Date	To What?	What Happened?	Treatment

Allergies (i.e. food, animals, medications, environmental, etc.) Y N

#### Special Dietary Needs: Y N

List:\_\_\_\_\_

Notes:

#### **Parents/Guardians**

Mother:	First Name:	Last Name:	
	Home Phone:		
	Education:		
	Occupation:		
	Employer Name:	_ Marital Status:	M S D W
	Step-Father's Name:		
Father:	First Name:	Last Name:	
	Home Phone:	Work Phone:	
	Education:		
	Occupation:		
	Employer Name:	_ Marital Status:	MSDW
	Step-Mother's Name:		
Primary	Caregiver: (If different from Mother/I	Father)	
	First Name:	Last Name:	
	Home Phone:	Work Phone:	
	Education:		
	Occupation:		
	Employer Name:	Marital Status:	M S D W

Name	Date of Birth	Relationship	Comments

Who does your child reside with? (i.e. brother, sister, grandparent, step-mom/dad, etc.)

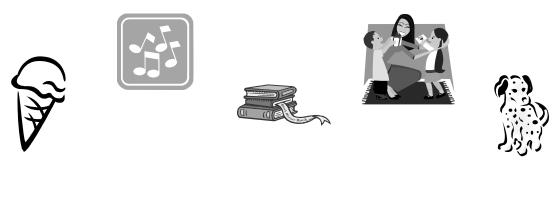
Notes:

**Personality Traits:** (i.e. tends to wander, bites, overly-friendly, etc.)

Likes:\_\_\_\_\_

Dislikes:

**Fears:** (i.e. storms, animals, dreams, etc.)



\_\_\_\_\_

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Т.	a				v	~0	٠

	Food:
	Music/Songs:
	Toys/Books:
	Persons:
	Animals:
Hobbies:	

Discipline is done by: Mother Father Step-Mother Step-Father Caregiver
Method of Discipline:

Child's Reaction:

Child's	Temper	<b>Tantrums:</b>
---------	--------	------------------

#### **Skills and Abilities:**

#### Self-Help

Feeds Self, Using:

	Fork	Y	Ν	With Assistance:	
	Spoo	on Y	Ν	With Assistance:	
	Knif	e Y	Ν	With Assistance:	
Bathes Self:	Y	Ν	W	/ith Assistance:	_
Dresses Self:	Y	Ν	W	/ith Assistance:	_
Undresses Self:	Y	Ν	W	/ith Assistance:	_
Toilet Trained:	Y	Ν	W	Vith Assistance:	

#### Indicate the age of your child when he/she could:

Hold Head up	Follow Object with Eyes
Roll	Play with Hands
Reach for Objects	Crawl
Get into Sitting Position	Sit Unsupported
Pull up to Stand	Stand Alone
Walk Alone	Ate Table Foods

#### **Daycare Experience:**

Date Started:	How long there:
Name of Provider:	
Type of Daycare:	
Positive Experiences:	
Negative Experiences:	

#### **General Development**

#### **Pregnancy and Birth History**

Problems with Pregnancy:	Y	Ν	
Problems with Delivery:	Y	Ν	
Length of Pregnancy:			

Health Problems during First Two Weeks of Child's Life:

(Paste Birth Announcement Here)

#### **Medical History**

**Diagnosed Medical Conditions:** 

Condition	When diagnosed?	Who Diagnosed?

General Health: Good Fair Poor

Explain:

Last Vision Exam:

Last Dental Exam:

History of Seizures, Convulsions, and/or Staring Spells: Y N

Explain:

Detail Hospitalizations, Serious Illnesses, Accidents, or Adverse Reaction to Immunizations:

### Family Medical History

#### **MOTHER'S FAMILY**

Relationship	Health Conditions/Illnesses	Date Diagnosed
Mother		
Grandmother		
Grandfather		
Aunt		
Uncle		

#### FATHER'S FAMILY

Relationship	Health Conditions/Illnesses	Date Diagnosed
Mother		
Grandmother		
Grandfather		
Aunt		
Uncle		

#### **CHILD'S SIBLINGS**

Relationship	Health Conditions/Illnesses	Date Diagnosed
Brother		
Brother		
Sister		
Sister		

### Family Medical History Cont.

#### **OTHER RELATIVES**

Relationship	Health Conditions/Illnesses	Date Diagnosed

Notes:

**Emergency Contact Person(s)** 

None:\_\_\_\_\_

	Relationship:         Work Phone:         Zip Code:
State:	_ Zip Code:
State:	
	Relationship:
	Work Phone:
<u> </u>	
State:	_ Zip Code:
	Relationship:
	Work Phone:
State:	_ Zip Code:
	Work Phone:
State:	Zip Code:
	Relationshin
	Relationship: Work Phone:
	Relationship: Work Phone:
	Relationship:      Work Phone:      Zip Code:
State:	Work Phone:
State:	Work Phone: Zip Code: Relationship:
State:	Work Phone:
	 State: e event of an

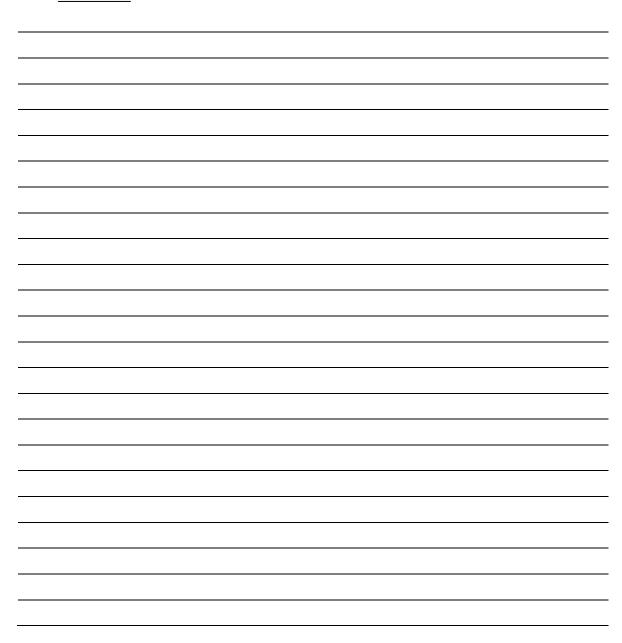
Family's religion and/or customs that may affect medical treatment of child: Y N

## **Medications**

DATE STARTED	DATE STOPPED	MEDICATION	PRESCRIBED FOR	DOSAGE	FREQUENCY	PRESCRIBED BY	ANY SIDE EFFECTS

# **Activities of Daily Living**

Use this page to describe your child's abilities to feed him/herself, bathe, get dressed, using the bathroom, combing hair, brushing teeth, etc.. Detail what your child can do by him/herself and any help or equipment your child uses for these activities. Describe any special routines your child has for bath time, getting dressed, etc...



## **Care Schedule**

### TIME

### <u>CARE</u>

Morning	

Afternoon	

# **Care Schedule**

### TIME

### <u>CARE</u>

Evening	

Over - Night	

## **Child's Page**

Use this page for your child's words and thoughts about his/her life in the past, now, as well as in the future.

Date:



# **Communication**

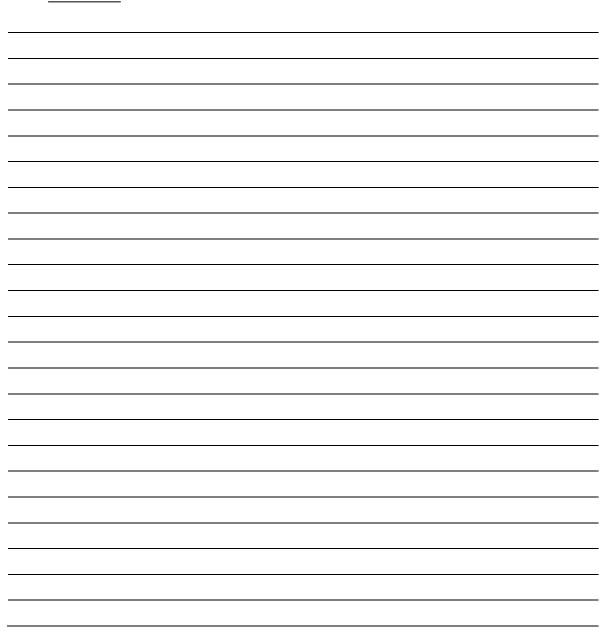
Use this page to describe your child's ability to communicate and to understand others. How does your child communicate? Include sign language words, gestures, equipment, or help your child uses to communicate and understand others. Include any special words your family and child use to describe things.



# **Coping and Stress Tolerance**

Use this page to describe how your child copes with stress. Stressful events might include new people, situations, hospital stay, or procedures such as having blood drawn. What upsets your child? What does your child do when he/she is upset? What happens when he/she has had "enough"? Describe your child's way of asking for help and things to do or say to comfort your child.

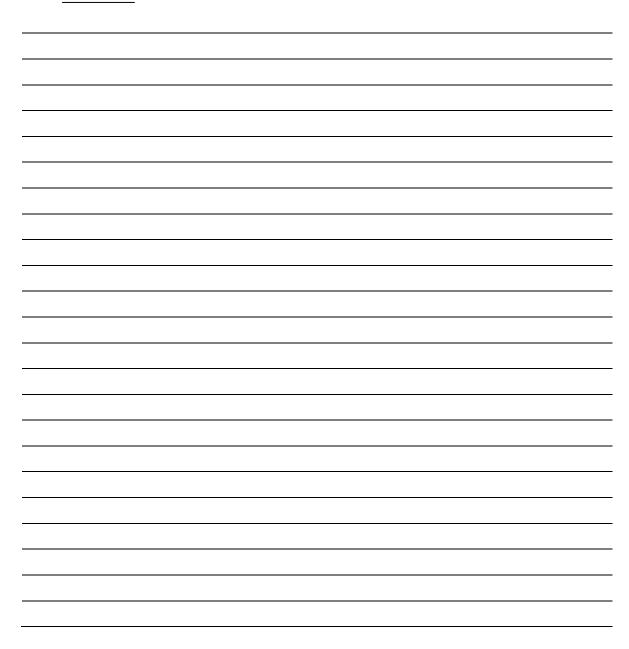
Date:



# **Mobility**

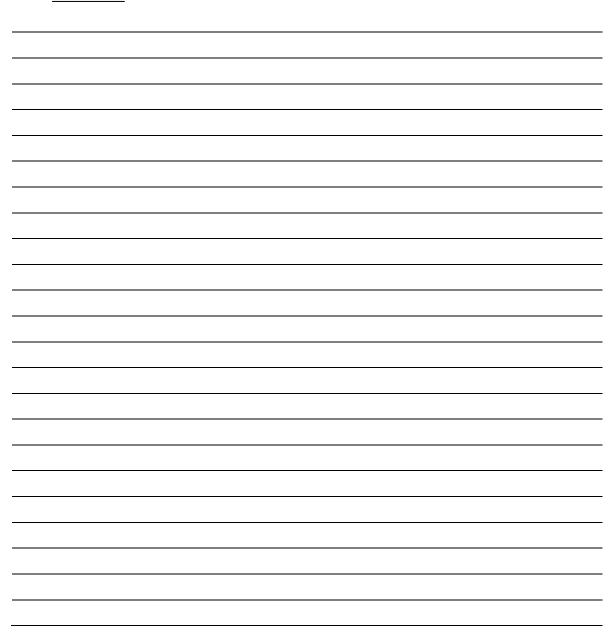
Use this page to describe your child's ability to get around. Include what your child can do by him/herself and any help or equipment your child uses to get around. Describe any activity limits and any special routines your child has for transfers, pressure releases, positioning, etc...

Date:



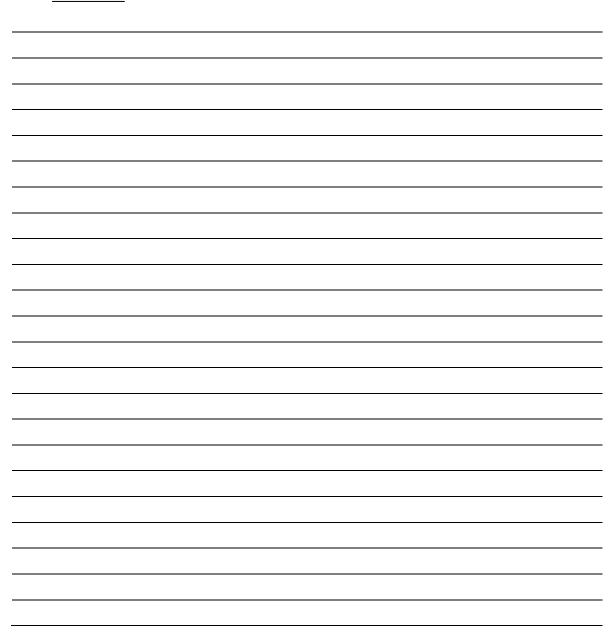
# **Nutrition**

Use this page to describe foods and any nutritional formulas your child takes, any food allergies or restrictions, and any special feeding techniques, precautions, or equipment used for feedings. Describe any special mealtime routines your family and child has.



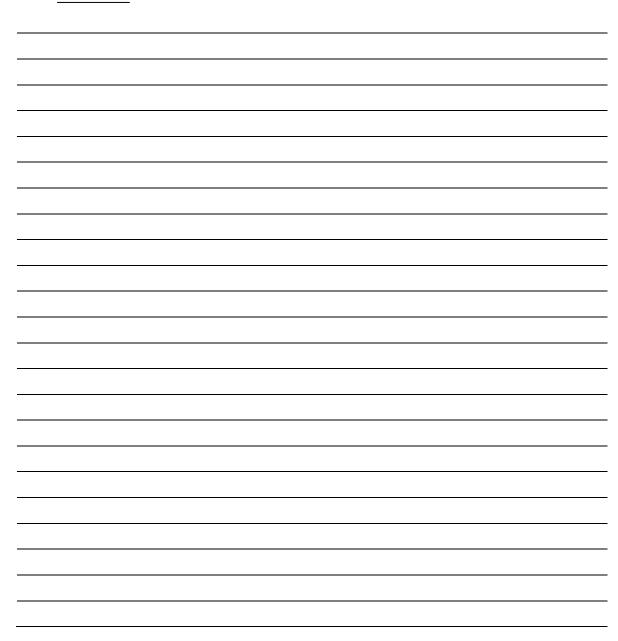
# **Respiratory**

Use this page to describe your child's respiratory care needs, treatment needs, and any special techniques or precautions you use when giving care. Include any special routines your child has for respiratory care.



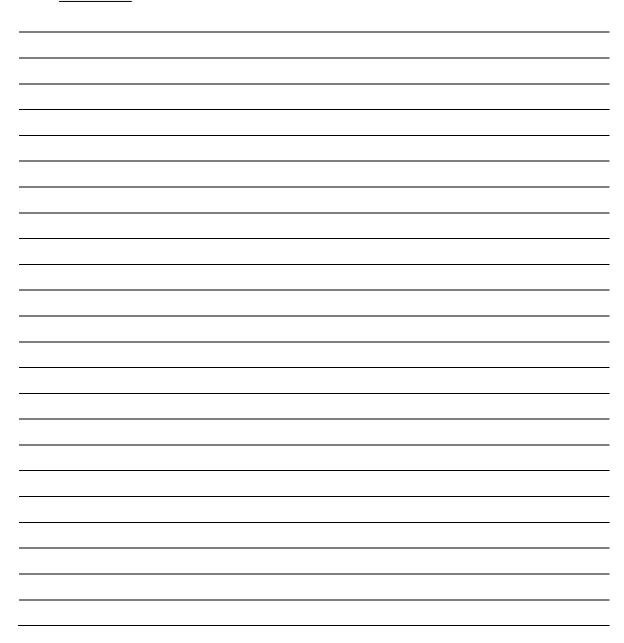
## **Rest and Sleep**

Use this page to describe your child's ability to get to sleep and to sleep through the night. Describe your child's bedtime routine and any security or comfort objects your child uses.



# **Social and Play**

Use this page to describe your child's ability to get along with others. Describe how your child shows affection, shares feelings, or plays with other children. Describe what works best to help your child get along or cooperate with others. Describe your child's favorite things to do. Include any special family activities or customs that are important.



## **Insurance Information**

Primary Insurance Company:	
Policy Number:	
Contact Person:	
Address:	
Phone:	Fax:
Secondary Insurance Company:	
Policy Number:	
Contact Person:	
Address:	
Phone:	Fax:
Medicaid (Name on card):	
ID Number:	
DFS Caseworker:	
Office/Location of DFS Caseworker:	
Phone:	Fax:
Other:	
Policy Number:	
Contact Person:	
Address:	
Phone:	Fax:

## **Family Support Resources**

Public Health Office:		
Contact Person:		
Address:		
Phone:		
Department of Family Services:		
Contact Person:		
Address:		
Phone:		
Counseling Services:		
Contact Person:		
Address:		
Phone:	Fax:	
Other:		
Contact Person:		
Address:		
Phone:		
Other:		
Contact Person:		
Address:		
Phone:	Fax:	

### AUTHORIZATION TO ADMINISTER MEDICATION

Name of Individual receiving medication:		
I/We,	, guardian/parent of	
, authorize		to
administer medications prescribed by his/h	her physician while in his/her care during our	
absence.		
	losage and administration information, and tha effects of the medications and reporting these	
I/We understand that this authorization wi	ll be in effect one year from the date signed.	
Guardian/Parent	Date:	
Guardian/Parent	Date:	

### AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

PLEASE COMPLETE THE FOLLOWI	NG: Place Current
	Picture
Child's Name:	of Child
Date of Birth:	
Date of Last Tetanus Shot:	
Current Medications:	
Allergies to Medication:	
Chronic Medical Conditions:	
care of	treatment/aid due to illness or injury while in the , I authorize medical or surgical care from y child. It is understood that a conscientious effort taken. If this is not possible, treatment as deemed
necessary by the healthcare facility/physician/d transportation of the above-named child to the n	•
Insurance Company that covers the above-name	ed child is:
Name of Insurance Company:	
Address:	
Phone:	
Name of Policy Holder:	Policy #:
Medicaid Client:	Medicaid #:
ACS Phone #:	(Attach copy of EqualityCare Card)
I authorize the hospital, and attending p and to Medicaid, and hereby assign benefits dir	ohysician/dentist to submit claims to this company
Name:Signature of Parent/Guardian	Date:
Witness:	Date
winness.	Date:

## **Medical/Dental Healthcare Providers**

Primary Care Provider:			
Date of First Visit:			
Phone:	Fax:	E-Mail:	
Community Hospital:			
Address:			
Phone:	Fax:	E-Mail:	
Dental Provider:			
Date of First Visit:			
Phone:	Fax:	E-Mail:	
Orthodontist:			
Date of First Visit:			
Address:			
Phone:	Fax:	E-Mail:	
		Date of First Visit:	
Office Nurse/Medical Ass	sistant:		
Address:			
Phone:	Fax:	E-Mail:	
Specialty Care Provider:			
Specialty:		Date of First Visit:	
Phone:	Fax:	E-Mail:	
Specialty Care Provider			
Specialty: Date of First Visit:			
Office Nurse/Medical Assistant:			
Address:			
Phone:	Fax:	E-Mail:	

There is more space to list Specialty Care Providers on the next page.

Specialty Care Provider:				
Specialty:		Date of First Visit:		
Office Nurse/Medical As	sistant:			
Address:				
Phone:	- Fax:	E-Mail:		
		Date of First Visit:		
Address:				
Phone:	- Fax:	E-Mail:		
Specialty Care Provider:				
		Date of First Visit:		
Phone:	- Fax:	E-Mail:		
1 2		Date of First Visit:		
Phone:	- Fax:	E-Mail:		
Specialty Care Provider				
		Date of First Visit:		
		E-Mail:		
I liolic.	- 1 <sup>a</sup>			
Specialty Care Provider:				
Specialty:		Date of First Visit:		
Office Nurse/Medical As	sistant:			
Address:				
Phone:	- Fax:	E-Mail:		
		Date of First Visit:		
Address:				
Phone:	– Fax:	E-Mail:		
Specialty Care Provider				
Specialty		Date of First Visit:		
Dhone	Fax	E-Mail:		
1 110110.	- 1°an			

## <u>Therapists</u>

Occupational Therapist (OT):		
Start Date:		
Agency/Hospital/Clinic:		
Address:		
Phone:	Fax:	 E-Mail:
Physical Therapist (PT):		
Start Date:		
Agency/Hospital/Clinic:		
Address:		
Phone:		
Filone	гах.——	E-Mail
Speech-Language Pathologist:		
Start Date:		
Agency/Hospital/Clinic:		
Address:		
Phone:		
Therapist:		
Start Date:		
Agency/Hospital/Clinic:		
Address:		
Phone:	Fax:	 E-Mail:
Therapist:		
Start Date:		
Agency/Hospital/Clinic:		
Address:		
Phone:	Fax:	 E-Mail:
Therapist:		
Start Date:		
Agency/Hospital/Clinic:		
Address:		
Phone:	Fax:	 E-Mail:

### **Respite Care**

Respite Care Provider:				
Start Date:		End Date:		
Agency:				
Address:				
Phone:	Fax:		E-Mail:	
Respite Care Provider:				
Start Date:		End Date:		
Agency:				
Address:				
Phone:	Fax:		E-Mail:	
Respite Care Provider:				
Start Date:				
Agency:				
Address:				
Phone:	Fax:		E-Mail:	

(Case Manager, Public Health Nurse, Service Coordinator, Respite, Children's Waiver, ECT.)

Services:	
Agency:	
Contact Person:	_ Phone:
a .	
Services:	
Agency:	
Contact Person:	_ Phone:
Services:	
Agency:	
Contact Person:	
Tape	Tape
Business	Business
Dusiness	Dusmess
	~ · ·
Card	Card
Here	Here
<b>T</b>	Π
Tape	Tape
Business	Business
Card	Card
Cuiu	Card
Here	Here

#### **Early Intervention**

Early intervention means early assistance where a special kind of partnership between parents and professionals gives every child the best possible start in life. The Department of Health's Early Intervention and Education program is designed to help your child and your family receive the support you want and need. This program is designed to identify children at risk in the earliest stages, when the right help can make all the difference. This program is to support eligible children and families in enhancing a child's potential growth and development from **birth to age three (0-3)**.

Early Intervention Program A	gency:	
Date Contacted:		Date Started:
Service Coordinator:		
Service Providers (therapists,	nurse, etc):	
Address:		
Phone:	Fax:	E-Mail:
Hours of Operation:		

## **Child Care**

Child Care Provider:			
Start Date:			
Address:			
Phone:	Fax:	E-Mail:	
Important Information:			
Child Care Provider:			
Start Date:			
Address:			
Phone:	Fax:	E-Mail:	
Important Information:			
Child Care Provider:			
Start Date:			
Address:			
Phone:	Fax:	E-Mail:	
Important Information:			

### **School Contacts**

School District:			-
Address:			
Phone:	Fax:	Website:	
Special Education Coord	rdinator:		_
Address:			
Phone:	Fax:	Website:	
504 Accommodation P	lan Coordinator (If	different from above):	
Address:			-
Phone:	Fax:	Website:	
District Nurse (Assigne Address:	ed to your child's sc	chool):	_
Phone:	Fax:	Website:	
School:		***************************************	*****
		E-Mail:	
Principal:			
Phone:	Fax:	E-Mail:	
Classroom Teacher:			
Phone:	Fax:	E-Mail:	
Resource Instructor:			
		E-Mail:	
Aide/Assistant/Interver	ner:		
		E-Mail:	
Special Education Disc	otor/Toooltor(a);		
		E-Mail:	
Phone:	Гал	L'-IVIAII	

### **Letter Writing**

#### What do you say in a letter?

- Write your own letter. Typed letters are easier to read, but handwritten letters are acceptable if they are legible. Your letter should not be longer than two pages.
- State your name, address, phone number, county you live in, e-mail address.
- State your reason for writing this letter. Explain how the issue affects you, your child, and those around you.
- Remember to tell your personal story. If possible, provide a photo of your child that you are writing about.
- Specifically, what are your concerns and questions? Be sure to include a question or request in the letter, so the person to whom you are writing can answer you.
- What would you like the person to whom you are writing to do about this situation? Say what you want, rather than what you don't want.
- If you want a response to your letter, ask for one. What sort of response do you want:
  - A letter
  - A meeting
  - A phone call
  - Something else?

#### What else do you need to say in your letter?

- Put your return address in your letter. Envelopes can be thrown away.
- Be sure there is a date on your letter.
- Keep a copy of your letter for your records.
- Be sure to give an address or daytime phone number where you can be reached.
- Thank them for their time and attention they are giving to your problem/issue.

#### Some reasons for writing a letter are to:

- Discuss a problem
- Request an evaluation(s)
- Request a meeting
- Make contact with someone
- Request records
- Write a follow-up letter
- Give positive feedback

#### **Other things:**

- Have someone proofread your letters
- Include attachment(s)/enclosure(s)
- C: copies to all persons necessary

## Letter Log

### Always keep a copy of every letter you write for your own records.

Date	To Whom	From Whom	Reason for Letter	Reply

## **Telephone Log**

### Always keep a log of telephone calls made for your own records.

Date	Time	Person Called	Reason for Calling	Response	Follow- Up

# **Diet Tracking Form**

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Tube Feeding							
Breakfast							
Lunch							
Dinner							
Snacks							

Notes:

# **Growth Tracking Form**

DATE	HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	CHECKED BY

# **Hospital Stay Tracking Form**

DATE	HOSPITAL	REASON	NOTES

# **Medical and Surgical Highlights**

DATE	PROCEDURE	RESULT	COMMENTS

# Lab Work/Tests/Procedures

DATE	TEST	RESULT	COMMENTS

# **Equipment**

Medical Equipment Su	applier (DME):		
Contact Person:			
Phone:	Fax:	E-Mail:	
		Г.):	
Equipment:			
Description:			
Date obtained:		Service Schedule:	
Contact Person:		Phone:	
Equipment:			
Description:			
Date obtained:		Service Schedule:	
Contact Person:		Phone:	
Equipment:			
Description:			
Date obtained:		Service Schedule:	
Contact Person:		Phone:	

# **Supplies**

Medical Equipment	Supplier (DME):		
Contact Person:			
Phone:	Fax:	E-Mail:	
Address:			
Notes (Delivery scł	edule, order schedule, etc):		

ITEM	DESCRIPTION	QUANTITY	NOTES

# **Medical Bill Communication Log**

Info	Information About the Bill			Information About Who You Talk To				Notes
Account #	Provider	Date of Service	What bill is for:	Date of Contact	Time	Title	Name	Notes

#### **Emergency Preparedness for Children with Special Health Care Needs**

Instructions for Parents

Dear Parent:

Children with special healthcare needs have very unique medical histories and require very special medical treatment. If an emergency physician does not have access to this important information, these children are in danger of delayed treatment, unnecessary tests, and even serious errors. It is extremely important, then, that parents and physicians work together to give emergency physicians access to the special information they need to properly care for children with very special healthcare needs.

To address this problem, the American Academy of Pediatrics and the American College of Emergency Physicians have developed the Emergency Information Form. This simple form is used to record health information for children with special healthcare needs and should be kept in multiple locations for easy access by physicians and emergency medical personnel.

To complete this important form, follow these easy instructions:

- 1. **GET THE FORM**: A copy has been provided for you in this notebook.
- 2. **FILL IT OUT**: Begin filling out the form to the best of your ability. Take the form to the child's primary care physician or specialist and ask them to finish filling out the form.
- 3. **KEEP IT**: Keep 1 copy of the form in each of the following places:
  - a. DOCTORS: On file with each of the child's physicians, including specialists.
  - b. ER: On file with the local emergency rooms where the child is most likely to be treated in the case of an emergency.
  - c. HOME: At the child's home in a place where it can be easily found, such as on the refrigerator.
  - d. VEHICLES: In each parent's vehicle (i.e., glove compartment).
  - e. WORK: At each parent's workplace.
  - f. PURSE/WALLET: In each parent's purse or wallet.
  - g. SCHOOL: On file with the child's school, such as in the school nurse's office.
  - h. CHILD'S BELONGINGS: With the child's belongings when traveling.
  - i. EMERGENCY CONTACT PERSON: At the home of the emergency contact person listed on the form.
- 4. **REGISTER**: Consider registering the child, if he or she is not already registered, with Medic Alert®. Send Medic Alert® a copy of the form so that they can keep it stored in their central database, which is easily accessible by emergency medical personnel.
- 5. **UPDATE**: It is extremely important that you update the form every 2-3 years, and after any of the following events:
  - a. Important changes in the child's condition.
  - b. The performance of any major procedure.
  - c. Important changes in the treatment plan.
  - d. Changes in physicians.

Now, if your child ever has an emergency, the emergency medical personnel will have easy access to your child's very unique medical history, allowing them to provide your child with the best medical care available.

Thank you for your cooperation!

Very truly yours, American Academy of Pediatrics American College of Emergency Physicians Emergency Medical Services for Children

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# **Emergency Information Form for Children With Special Needs**

American College of Emergency Physicians\*

American Academy of Pediatrics



Revised Revised Initials Initials

Name:	Birth date: Nickname:
Home Address:	Home/Work Phone:
Parent/Guardian:	Emergency Contact Names & Relationship:
Signature/Consent*:	
Primary Language:	Phone Number(s):
Physicians:	
Primary care physician:	Emergency Phone:
	Fax:
Current Specialty physician:	Emergency Phone:
Specialty:	Fax:
Current Specialty physician:	Emergency Phone:
Specialty:	Fax:
Anticipated Primary ED:	Pharmacy:
Anticipated Tertiary Care Center:	
Diagnoses/Past Procedures/Physical Exam:	
1	Baseline physical findings:
2.	
3.	Baseline vital signs:
4.	
Synopsis:	
	Baseline neurological status:

\*Consent for release of this form to health care providers

Diagnoses/Past Procedures/Physical Exam continued:	
Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	Prostheses/Appliances/Advanced Technology Devices:
5.	
6.	

Manage	ement Data:		
	Allergies: Medications/Foods to be avoided	and why:	
1.			
2.			
3.			
	Procedures to be avoided	and why:	
1.			
2.			
3.			

Immun	izations (mm	ı/yy)							
Dates					Dates				
DPT					Hep B				
OPV					Varicella				
MMR					TB status				
HIB					Other				
	Antibiotic pror	hvlaxis <sup>.</sup>		Indicatio	n.	Me	dication and	l dose:	

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature:

Print Name:

Last name:

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**Emergency Contact Person(s)** 

None:\_\_\_\_\_

Name:		Relationship:
Home Phone:		Work Phone:
Address:		
City:	State:	_ Zip Code:
Name:		Relationship:
Home Phone:		Work Phone:
Address:		
City:	State:	_ Zip Code:
Name:		Relationship:
Home Phone:		Work Phone:
Address:		
City:	State:	_ Zip Code:
friends, etc) Name <u>:</u>		emergency? (Clergy, other relatives, Relationship:
friends, etc) Name: Home Phone:		
friends, etc) Name <u>:</u>		Relationship:
friends, etc) Name: Home Phone: Address: City:	State:	Relationship:     Work Phone:     Zip Code:
friends, etc) Name: Home Phone: Address: City: Name:	State:	Relationship:       Work Phone:       Zip Code:       Relationship:
friends, etc) Name: Home Phone: Address: City: Name: Home Phone:	State:	Relationship:     Work Phone:     Zip Code:
friends, etc) Name: Address: City: Name: Home Phone: Address:	State:	Relationship:       Work Phone:       Zip Code:       Relationship:
friends, etc) Name: Address: City: Name: Home Phone: Address:	State:	Relationship:       Work Phone:      Zip Code:       Relationship:       Work Phone:
friends, etc) Name: Address: Name: Home Phone: Address: City: Name:	State:	Relationship:   Work Phone:   Zip Code:   Relationship:   Work Phone:   Zip Code:
friends, etc) Name: Home Phone: Address: City: Name: Home Phone: Address: City:	State:	Relationship:         Work Phone:         Zip Code:         Relationship:         Work Phone:         Zip Code:         Relationship:         Relationship:         Relationship:

Family's religion and/or customs that may affect medical treatment of child: Y N

## **Transitioning: A Time of Change**

Workbook

Your child and family will experience many transitions, small and large, over time. Three predictable transitions occur for most children: reaching school age, approaching adolescence, and moving from adolescence to adulthood. Children with special healthcare needs and/or disabilities do not experience these transitions in the way most children experience them. Other transitions may involve moving into new programs, working with new agencies and care providers, or making new friends. Transitions involve changes: adding new expectations, responsibilities, or resources and letting go.

The goal of this workbook is to organize the transition process into a smooth, successful move from pediatric focused to adult focused. Please feel free to use these pages as they seem to make sense for you. This workbook is not meant to substitute for other transition resources you may have available to you from the school system or community. Transition is a comprehensive process involving all facets of your life.

Looking at transitions may be hard, depending on your circumstances. You may have limited time just to do what needs to get done today. You may find it helpful, though, to jot down a few ideas about your child's and family's future. You might start by thinking about your child's and family's strengths. How can these strengths help you plan for "what's next" and reaching long-term goals? What are your dreams and your fears about your child's future?

This workbook is really about your child and family! The final decisions about what to include in these pages should ultimately be your decision. There is no rush, so be thoughtful about what you include as you walk through these pages. Most of all have fun! This is a great opportunity to learn more about your child's health and how it can affect the rest of his/her life.

#### **Suggestions for Transitioning to Adulthood**

Teens and young adults should be active participants in the transition to adult services. This is a time for parental support without being overprotective. "Letting go" is a necessary process experienced by both parent and young adult. Where do you start? Choose a goal that your young adult feels is most important to his or her independence and identify "safety nets." Safety nets are smaller steps taken to achieve independence and the support that is needed to assist them on their journey. Having these safety nets in place will make it much easier to transfer the responsibility to your young adult.

Following is a list of some of the health concerns parents should consider in their child's transition to adulthood. <u>This does not include individuals whose disability requires legal</u> guardianship by another person.

- < Guardianship
  - At age 18, in most states, adolescents reach the age of majority and are expected to make decisions about their own care.
  - Parents discover, by law, their young adult cannot be dependent forever.
  - Begin to think and plan for YOUR future as your teen becomes a young adult.
  - Please contact Sue Midland at (307)635-8422 for information on Guardianship.
- < SSI (short for Supplemental Security Income)
  - A person of any age can receive SSI, if they are disabled and meet the income and asset limits. In the case of minor children who live with their parents. We must also consider the parents' income and assets. Once a child is 18 we no longer consider parental income or assets.
  - Disabled means you have a physical or mental problem that keeps you from working and is expected to last at least a year or to result in death.
  - For more information about benefits for your young adult, please contact the Social Security Administration at 1-800-772-1213.
  - Take a look at SSA's **Listings** of Impairments and analyze if your disability(ies) may qualify:

#### http://www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm

- < Health care providers
  - Allow time for your teen or young adult and the doctor to be alone during an appointment. It is important that he/she have time to ask the doctor questions when you are not present. This conveys to the doctor that they are competent to ask personal questions and get correct information.
  - You and your young adult should talk to your doctor about his or her future medical needs.
- < Health care after graduation from high school
  - Who is responsible for making doctor appointments and getting prescriptions filled?
  - Does your young adult know about his or her illness or disability?
  - Do they know their rights to medical information, to decline services, and to understand complications of a medical procedure?

- Are they able to communicate their needs to the doctor or be comfortable in asking that all communication be written down to help them remember correctly?
- Who is responsible for hiring and firing live-in attendants to assist your young adult through the day or evening?
- There is a free guide you may find helpful in the decisions and choices ahead of you and your child: **Parents' Guide to Transition: What Happens After High School?** You can find it on the internet at <u>http://www.pluk.org/trans.html.</u> It will answer many of the questions listed above as well as others. If you are unable to access this guide, call (307)777-3637 and we will ship you a hard copy.
- < Addressing your young adult's health needs on the job, Mental Health issues
  - Who is responsible for scheduling of medication to be taken while at work?
  - Is it necessary for an employer or a mentor to know about medications and the effects it could have on your young adult while they are at work? (Consider work schedule versus medication schedule.)
  - Are there certain tasks and/or machinery that should not be assigned?
- < Sexuality
  - What is sexuality? It is having friends, caring about others, being needed, being loved and having opportunities to be with others. It is also holding hands, putting a head on a shoulder, hugging, touching or kissing. Ignoring sexuality has profound effects on body image, self-identity and self-esteem in the teen or young adult.
  - Knowing the answers to sexual questions reduces vulnerability. Parents are in the best position to teach sexuality to their teen or young adult. Parents are the constant in their child's life and they know them best. If you need further resources to introduce your teen or young adult to his or her sexuality, don't be afraid to ask for help. Disability organizations, parenting groups, teachers and doctors can provide resources and information.
- < Health insurance, medication and appliances
  - The *FIRST STEP* is to read your insurance policy or call your claims representative at your insurance company to find out what age your young adult may lose coverage on the family health insurance.
  - If your teenager turns 18, completes high school and does not go on for further schooling, he or she may no longer be eligible for the family's insurance.
- < Involve your young adult in discussions about health care financing.
- < Learn what questions to ask as you explore insurance options. Be sure the plan will meet your young adult's needs. Here are some questions to consider:
  - What are the specific needs of your young adult?
  - What are the medication costs?
  - Does the plan cover home care?
  - Does the plan cover durable medical equipment (i.e., wheelchair, glucose monitors)?
  - Is physical, occupational or speech therapy covered in the plan?

#### **My Story**

My hobbies are: My favorite things are: I am unique because: The activities I am involved in are: In five years I hope to: Use the back of this page to write other interesting information about

yourself that you would like for your new doctor to know. Do you have any fears or concerns about the transition process?

### **Family Information**

My name:	Nickname(s):				
Date of Birth:	Social Security Number:				
Address:					
Phone number:					
~~~~~~~~~~~		~~~~~~			
Emergency Contact Person:					
Daytime Phone:	Evening Phone:				
	_				
Address:					
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~			
Guardian (if "self" please indicate)					
Daytime Phone:	Evening Phone:				
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	.~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~			
Parent's Names:					
Daytime Phone:	Evening Phone:				
Address:					
Contact in an Emergency?					
~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~			
Siblings Names:					
Provide Contact Information:					
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~			
People who live with me:					
Name:	Relationship:				
Name:					
	Relationship:				
	Relationship:				
Name:					
	Relationship:				
Name:	Relationship:				

### **Community Contact Information:**

School Name:		
Grade or year in school:		
School Phone: C	ontact Person:	
Academic Counselor:		
	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
Local Public Health Office:		
Case Manager/Title:		
Address:	Even in a Dhanna	
Daytime phone:	Evening Phone:	
Fax:	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~
Other Case Management:		
Case Manager/Title:		
Address:		
Daytime phone:	Evening Phone:	
Fax:	-	
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~
Durable Medical Equipment Company:		
Case Manager/Title:		
Address:		
Daytime phone:	Evening Phone:	
Fax:		
	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
Church or Religious Community:		
Daytime Phone:	Evening Phone:	
Address:		
Contact in an Emergency?		
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~

Other Important Personal or Family Information Please Continue on the back of this page.

### Household Emergency Information

My Address:
Directions to my house:
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Fire Department Number: 911 or
Police Department Number: 911 or
Ambulance: 911 or
Poison Control Hotline:
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Fire Escape Plan :
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Check smoke alarms monthly!

Check fire extinguishers monthly!

#### **Care Plan for Behavior Disorders**

Crisis Hotline:	Case Manager Phone:
	Phone:
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
~~~~~~	
What behavior pattern is typical for	this individual? Include affect, seasonal changes etc.
what behavior pattern is typical for	tuns murviduar: menude arreet, seasonar enanges etc.
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Worrisome Behavior to Watch for:	
Action Plan:	
2.	
3	
Intermediate Dangerous Behavior:	
Action Plan:	
2	
3	
Dangerous Behavior:	
Dungerous Denuvior.	
Action Plan:	
1	
2.	
3	

Extremely Dangerous Behavior: CALL 911

#### **Care Plan for Medical Disorders**

	Case Manager Phone: Phone:
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
What medical symptoms are typical for the problems, physical symptoms etc. of freq	
Worrisome Symptoms to Watch for:	
Worsening Symptoms:	
Action Plan:	
Dangerous Symptoms:	
Action Plan:	
2 3	
J	

Life Threatening Situations: CALL 911

#### Medical Summary Reflecting the Most Recent Complete Physical Examination

Insert a copy of the most recent history and physical exam done by your primary care doctor. If you have several specialists include their most recent report summarizing your care.

- Have you thought about gynecological issues such as contraception?
- Are there any other concerns that need to be discussed dealing with family planning or sexuality?
- Are there any serious ongoing issues that are in the process of being evaluated or any recent changes to medicines or therapies?

### **Current Medication Summary Sheet**

Drug Name	Date Started	Date Ended	Dosage	Frequency Given	Reason For Taking	Observed Side Effects

#### **Medications That Didn't Work**

Name of Drug	Date Started	Date Ended	<b>Dosage/Frequency</b>	<b>Reason for Stopping</b>

### **Immunization History**

Insert a copy of your immunization record here.

#### **Disease History:**

Chicken Pox	
Hepatitis B	
Hepatitis A	
Other	

#### **Doctor Contact Information**

Primary Care Provider:		
Address:		
Phone:	Fax:	
Emergency/After Hours Number:		
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Counselor/Therapist:		
Address: Phone:	Fax	
Emergency/After Hours Number:		
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~	
Specialist Provider:		Specialty:
Address:		
Phone:	Fax:	
Emergency/After Hours Number:		
Specialist Provider:		
Phone:	Fax:	
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Phone:	Fax:	
Emergency/After Hours Number:		
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Specialist Provider:		Specialty:
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Specialist Provider:		Specialty:
Address:		
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Address: Phone:	Fax	
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Specialist Provider:		
Address:		
Phone:		
Emergency/After Hours Number:		
Spacialist Dravidant	~~~~~~	Specialty,
Specialist Provider:		
Address:	Eov	
Phone: Emergency/After Hours Number:		
~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Specialist Provider:		Specialty:
Address:		
Phone:		
Emergency/After Hours Number:		
Dentist:		
Address:		
Phone:	Fax:	
Emergency/After Hours Number:		

Physical Therapist:	
Address:	<b>F</b>
Phone:	Fax:
Emergency/After Hours Number:	
	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Address:	
Phone:	Fax:
	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Speech-Language Pathologist: Address:	
Phone:	Fax:
Emergency/After Hours Number:	
Eye Care Provider :	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Address:	
Phone:	Fax:
Emergency/After Hours Number:	
••••••	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Address:	
Phone:	Fax:
Emergency/After Hours Number:	
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Address:	
Phone:	Fax:
	I u.x
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

We encourage you to take the next section of documents to your healthcare professional(s), this way the proper information can be filled in correctly.

### **Care Summary Sheet – Primary Care**

Date:	Contact Number:
Provider: Reason for visit:	
Diagnosis:	
Treatment :	
Follow Up Appointment:	
Do you anticipate transition fro If so, do you have an adult prov	om your care to another provider for adult services? vider to refer this patient to?
Care S	ummary Sheet – Specialist
Date:	Contact Number:
Provider: Reason for visit:	
Diagnosis:	
Treatment :	
Follow Up Appointment:	
Do you anticipate transition fro If so, do you have an adult prov	om your care to another provider for adult services? vider to refer this patient to?

#### **Care Summary Sheet – Specialist**

Date:	Contact Number:			
Provider:	der: Specialty:			
Reason for visit:				
Diagnosis:				
Treatment :				
Follow Up Appointment:				
	on from your care to another provider for adult services? t provider to refer this patient to?			
Ca	re Summary Sheet – Specialist			
Date:	Contact Number:			
Provider:	Specialty:			
Reason for visit:				

Diagnosis:

Treatment : \_\_\_\_\_

Follow Up Appointment: \_\_\_\_\_

Do you anticipate transition from your care to another provider for adult services? If so, do you have an adult provider to refer this patient to?

# **Care Summary Sheet – Dentist**

Date:	Contact Number:	
Provider:		
Reason for visit:		
Diagnosis:		
Treatment :		
Follow Up Appointment:		
	rom your care to another provider for adult services? ovider to refer this patient to?	
Care	Summary Sheet – Eye Care	
Date:	Contact Number:	
Provider:		
Reason for visit:		
Diagnosis:		
Treatment :		
Follow Up Appointment:		
	rom your care to another provider for adult services? ovider to refer this patient to?	

# **Care Summary Sheet – Counselor Therapist**

Date:	Contact Number:		
Reason for visit:			
Diagnosis: Axis I			
Axis III			
Axis IV			
Treatment Goal :			
Treatment Method:			
Follow Up Appointment:			
Do you anticipate transition from If so, do you have an adult provi	m your care to another provider for adult services? ider to refer this patient to?		
Care Su	mmary Sheet – Psychiatry		
Date:	Contact number:		
Reason for visit:			
Diagnosis: Axis I			
Δ x is III			
Axis IV			
Treatment Goal:			
Treatment Method:			
Follow Up Appointment:			

Do you anticipate transition from your care to another provider for adult services? If so, do you have an adult provider to refer this patient to?

# **Insurance Information**

The **<u>FIRST STEP</u>** is to read your insurance policy or call your claims representative at your insurance company.

Involve yourself and your parents in discussions about healthcare financing

Learn what questions to ask as your explore healthcare financing. Be sure the plan will meet your needs. Below are questions to consider:

- What are my specific needs?
- What are my out of pocket expenses? Medication costs?
- Do I need a referral?
- Does my insurance change with age or school status?
- Does my insurance change with employment status?
- If my insurance changes, are there certain services that will be less available after I reach a certain age?
- Does the plan cover home care?
- Does the plan cover durable medical equipment (e.g., wheelchair, glucose monitors, etc...)?
- Is physical, occupational, or speech therapy covered in the plan?

#### IF YOU CAN'T ANSWER THE QUESTIONS ABOVE, THE TIME TO FIND OUT ABOUT YOUR COVERAGE IS <u>NOW</u>!!

Primary Insurance:	Plan number:
Group number:	ID number:
Subscriber's name:	
Subscriber's Social Security Number:	
Mailing address:	
Phone:	Fax:
Secondary Insurance:	Plan number:
•	
Subscriber's name:	ID number:
Subscriber's Social Security Number:	
Mailing address:	
Phone:	_ Fax:

Other Insurance:	Plan number:
Group number:	ID number:
Subscriber's name:	
Subscriber's Social Security Number:	
Mailing address:	
Phone:	_ Fax:
Other Insurance:	Plan number:
	ID number:
Subscriber's name:	
Subscriber's Social Security Number:	
Mailing address:	
Phone:	_ Fax:

### **Insurance Considerations**

#### **Adult Home and Community-Based Waiver**

#### http://wdh.state.wy.us/ddd/waiver.asp

• In order to be eligible for the adult waiver, an individual must be no younger than 21 years of age, a citizen of the United States, and a resident of Wyoming. They must be mentally retarded or meet the federal definition for developmental disabilities and they must be eligible to receive the level of care of an Intermediate Care Facility for the Mentally Retarded (ICF/MR)

#### WYOMING HEALTH INSURANCE POOL (WHIP)

http://insurance.state.wy.us/consumfm/pdf/WHIP%20Brochure%204-06.pdf

• The Wyoming Health Insurance Pool was created by the 1990 Wyoming Legislature to provide health insurance coverage to residents of Wyoming who are denied adequate health insurance. This plan is specially designed to meet the needs of those individuals who are unable to purchase health insurance for themselves because of existing health problems

#### **Social Security Income (SSI)**

http://www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm

- A person of any age can receive SSI, if they are disabled and meet the income and asset limits. In the case of minor children who live with their parents. We must also consider the parents' income and assets. Once a child is 18 we no longer consider parental income or assets
- Disabled means you have a physical or mental problem that keeps you from working and is expected to last at least a year or to result in death
- For more information about benefits for your young adult, please contact the Social Security Administration at 1-800-772-1213

#### **Department of Family Services**

http://dfsweb.state.wy.us/

- Parent(s) with children who have qualifying income.
- Pregnant women.
- Children through the age of 18
- A child with special health needs who may be eligible for the Children's Special Health (CSH) program.
- Individuals receiving Supplemental Security Income (SSI) through Social Security.
- Individuals no longer receiving Supplemental Security Income (SSI) through Social Security.
- Individuals receiving Social Security benefits who are eligible for Medicare Part B Insurance.
- Individuals in need of nursing home care.
- Individuals who need care in an Assisted Living Facility
- Individuals who are developmentally disabled.
- Individuals who need nursing home care but wish to remain in their home.
- Individuals who are disabled and working.
- Individuals who are in need of hospice care.
- Individuals with an acquired brain injury.
- Individuals who need help with prescription drugs.
- Individuals who are qualified or non-qualified aliens.

#### **Prescription Drug Assistance Program**

http://wdh.state.wy.us/pharmacy/PDAP.asp

The Prescription Drug Assistance Program is a state funded pharmaceutical assistance program. For qualifying individuals, the benefit allows three (3) prescriptions per month. Prescriptions are limited to a month's supply and the co-pay is **\$10 per prescription for a generic drug and \$25 per prescription for a brand-name drug.** Eligibility for the program is determined by the Department of Family Services and clients are eligible for a period of one year.

# Mental Health Testing and Monitoring

Insert copies of any psychological testing results done to date in this section. If applicable include the most recent Ames test for psychotropic medication monitoring.

#### **Other Transition Areas To Consider:**

If you have one, a copy of your most recent IEP should be included here.

Other questions to answer are:

• Do I need a vocational rehabilitation advisor to transition from school to work? If yes...

Name of Contact:
Phone number:
Date Contact Initiated:
First Meeting Date:
TO DO List Prior to the First Meeting:

• Do I need an independent living advisor to transition from home to adult living? If yes...

Name of Contact:	
Phone number:	
Date Contact Initiated:	
First Meeting Date:	
TO DO List Prior to the First Meeting:	

• Do I need any additional help transitioning from secondary school to college or technical school? If yes...

\_\_\_\_\_

lame of Contact:
hone number:
Date Contact Initiated:
irst Meeting Date:
O DO List Prior to the First Meeting:

• Do I need help managing my transportation needs in order to meet my transition goals? If yes...

Name of Social Worker: \_\_\_\_\_\_ Phone number: \_\_\_\_\_\_ Date Contact Initiated: \_\_\_\_\_ First Meeting Date: \_\_\_\_\_ TO DO List Prior to the First Meeting: \_\_\_\_\_

• Do I have any other needs that need to be met prior to implementing my transition plan? If yes list them here and talk to your doctor.

# **CONGRATULATIONS!!!**

# YOU'RE READY TO TRANSITION!!

Notes:			

Notes:			
-			
_	_		



#### 8.3

# **Glossary of Commonly Used Terms**

Advocate	An advocate is someone who can listen to your problems and ideas, this person will help you make decisions or final solutions.
ADA	Americans with Disabilities Act – A law that supplements civil rights legislation enacted under the Rehabilitation Action Act. ADA prohibits discrimination against individuals with disabilities.
Assessment	A way of collecting information about a child's needs, strengths, and interests.
Care Coordination	Services are provided in a manner that the family's lifestyle is interrupted as little as possible, and the family's and child's needs are met.
Case Manager	A person who works with the family to plan for services and who coordinates many service providers. (Also called a Service Coordinator)
Chronic	A description of an illness/condition which lasts throughout a person's life.
Community-Based	High quality services necessary to meet the daily needs of the child and his/her family located near their home.
Confidentiality	Your child's records and information will be shared only with people directly involved in your child's care, (e.g., medical or educational providers, etc.) which uphold the child's right to privacy.
CSH	Children's Special Health - A state program to assist children who have special health care needs.
DDD	Division of Developmental Disabilities
Diagnosis	The name of a condition or illness.

Disability	The result of any physical or mental condition that affects a person's ability to develop, achieve or function.
Discharge Planning	A plan for continuing care after your child has a hospital stay. Another goal of discharge planning is to help the health care team make sure your child has the resources that he/she needs in their community.
DFS	Department of Family Services.
DME	Durable Medical Equipment - Health care equipment that can be used over and over again (e.g., hospital beds, ventilators, I.V. Poles, wheelchairs, and walkers).
ΕΙ	Early Intervention - Part C serves children 0 to 6 years of age and their families.
Eligible	Meeting specific requirements to qualify for a program or service.
EPSDT	Early Periodic Screening Diagnosis and Treatment.
Evaluation	A way of collecting information about a child's needs, strengths, and interests.
Family-Centered Care	Services are delivered in a way that respects the central role of the family as caregiver, advocate, and decision-maker for the child.
Genetic Disease or Disorder	A disease that passes by gene from parent to child.
Health Care Professionals	Workers who have healthcare skills (Including nurses, doctors, social workers, physical therapists, pharmacists, and so on).
HMG-SK	Help Me Grow-Safe Kids

НМО	Health Maintenance Organization - A medical insurance program which gives care through specified doctors and hospitals. Members pay a fixed prepaid premium.
Inclusive Education	Children with special needs are educated with children that do not have special needs. Classroom assignments are adapted so the child with special needs can interact with the other children in the class.
IDEA	Stands for <i>Individuals with Disabilities</i> <i>Education Act, from</i> the federal law "Education for all Handicapped Children Act" (P.L. 94-142). A student must be enrolled in special education in order to receive the services mandated by IDEA. Students with a wide range of disabilities may be eligible for special education and related services.
IEP	Individualized Education Plan - A special education service plan for your child required by law for all students receiving special education services. The IEP outlines your child's educational goals and any services or assistance your child needs to meet those goals.
IFSP	Individual Family Service Plan - A service plan for a child 1-36 months of age and their family. The IFSP outlines services and goals of the family with the service providers. It can include services from human services departments and public and private agencies.
LRE	Least Restrictive Environment - This means a child with special needs is educated as much as possible with children who do not have special needs. The school program should still meet all of the child's educational needs. ("Mainstream", "Integration", "Inclusion").

O.T./OT	Occupational Therapy - Treatment to help a person develop mental or physical skills to aid in daily living. It focuses on hand and finger movement, and self-help skills such as dressing or using a fork and spoon.
Pediatric	A branch of medicine dealing with the care of children.
Pediatric Specialist	1. A pediatrician who has a specialty area of knowledge and skills. Examples are pediatric oncologist and neonatologist.
	2. A physician specialist who completed special training to treat children. The physician could be a pediatric surgeon, pediatric anesthesiologist or a pediatric urologist, for example.
Pediatrician	A doctor who specializes in the care of children.
PHN	Public Health Nurse.
Primary Care Provider	A physician or clinician whose practice focuses upon internal medicine, family/general practice, pediatrics, and obstetrics/gynecology.
P.T./PT	Physical Therapy - Treatment of physical disabilities by a physical therapist. It includes the use of massage and exercise to help the person improve the use of bones, muscles, joints, and nerves.
PL	Public Law - Federal law that is passed. The number that follows "PL" identifies the law, (E.g., PL 101-476).
<b>Respite</b> (Pronounced RES-pit.)	Care for a limited time, in which a family gets a much needed "break" from caring for their child with special needs.

Service Coordinator	A person who works with the family to plan for services and who communicates with many service providers (Also called Case Manager).
S.S.I./SSI	Supplemental Security Income - A cash assistance federal program that pays benefits to children with disabilities under age 18 whose families have limited income or resources. You can get more information by calling 1-800-772-1213.
Special Needs	A term used to describe persons with one or more mental, emotional, or physical conditions that limit their capacity to participate in normal activities.
W.I.C./WIC	The Special Supplemental Food Program for Women, Infants and Children - A program that provides food and nutrition education to prevent or correct malnutrition in pregnant women, new mothers and children up to age five. The program also screens for other health problems and makes referrals to other health and social services.

### **Resources**

Connect Wyoming Laramie, WY 82071

307-766-2996

Connect Wyoming is a human services infrastructure designed to service the state of Wyoming. It consists of a website hosting a searchable version of the Pathway's Plus database, a calendar of human service events, a monthly newsletter, and special Pathway's search interfaces for Medicaid Waiver Providers, Senior Services and the Wyoming Breast Cancer Resource Directory. The Pathways Plus database contains more than 3400 human service programs, and a browseable version is available on a free CD. Finally, Connect Wyoming forms partnerships with other agencies to produce specialized print directories, web interfaces, and other information formats.

#### Pathways Plus Services

http://wind.uwyo.edu/connect/default.asp

The Pathways Plus database provides the most current and comprehensive access to human services information in the state. Pathways has been designed so that the information contained in the database can be extracted and used in a variety of ways. Services currently provided through Pathways Plus include:

- Online searching (Basic and Advanced)
- Online subject browsing
- Browseable desktop version
- Print directories for each county available through the website
- Special search pages for Seniors, Breast Cancer, and Medicaid Waiver Providers

Pathways Plus services are constantly growing and improving. Please check the site often for the latest development.

Included in this Packaging Wisdom notebook is a copy of Connect Wyoming CD. You can also access the information at <u>http://wind.uwyo.edu/connect/default.asp</u>

# Wyoming County Public Health Offices

Albany County Public Health	307-721-2561
Big Horn County Public Health	
Greybull Office	307-765-2371
Lovell Office	307-548-6591
Campbell County Public Health	307-682-7275
Carbon County Public Health	
Rawlins Office	307-328-2607
Saratoga Office	307-326-5371
<b>Converse County Public Health</b>	
Douglas Office	307-358-2536
Glenrock Office	307-436-9376
Crook County Public Health	307-283-1142
Fremont County Public Health	
Lander Office	307-332-1073
Riverton Office	307-856-6979
Goshen County Public Health	307-532-4069
Hot Springs County Public Health	307-864-3311
Johnson County Public Health	307-684-2564
Laramie County Public Health	307-633-4000
Lincoln County Public Health	
Kemmerer Office	307-877-3780
Afton Office	307-885-9598
Natrona County Public Health	307-235-9340
Niobrara County Public Health	307-334-2609
Park County Public Health	
Cody Office	307-527-8570
Powell Office	307-754-8870
Platte County Public Health	307-322-2540
Sheridan County Public Health	307-672-5169
Sublette County Public Health	307-367-2157
Sweetwater County Public Health	
Rock Springs Office	307-352-6830
Green River Office	307-872-6320
Teton County Public Health	307-733-6401
Uinta County Public Health	
Evanston Office	307-789-9203
Lyman Office	307-787-3800
Washakie County Public Health	307-347-3278
Weston County Public Health	307-746-4775