CARE COORDINATION PLAN

NORTH DAKOTA DEPARTMENT OF HEALTH
CHILDREN'S SPECIAL HEALTH SERVICES (CSHS)
SFN 835 (8-2014)

Clear Fields

Note: Form must be completed by the CSSB Representative/Care Coordinator with the client's/family's input.

Client's Name:	Birthdate:

MEDICAL NEEDS/MEDICAL MANAGEMENT:

List **ALL** medical, dental and emotional/behavioral conditions, including any health issues that are currently **NOT** eligible under CSHS. Are medical needs easily managed in-state or are they complex enough to require consultation from several different pediatric specialists or management by a multidisciplinary team? Does the client require more health-related services than is usual for a child his or her age (e.g. vision care, dental care, medications, equipment/supplies, mental health services, home health, nutrition services, therapies, early intervention, special education, vocational rehabilitation, etc.) (Describe)

Current Providers:

Primary Care Provider/Medical Home Provider

Name	Clinic Name
Address	City

Medical Specialists/Clinic Team

Name	Clinic Name
Address	City

Dentist/Dental Home Provider

Name	Clinic Name
Address	City

Orthodontist

Name	Clinic Name
Address	City

Other

Name	Clinic Name
Address	City

Plan/Interventions: (Check all that apply)

- ☐ Link client/family to a PCP/Medical Home – refer to CSHS specialist list
- ☐ Link client/family to a general dentist
- ☐ Link client/family to a medical or dental specialist –refer to CSHS specialist list
- ☐ Link client/family to a specialty program or team clinic – refer to CSHS clinic directory
- ☐ Arrange appointments
- ☐ Help client/family locate, arrange, or secure medical-related travel
- ☐ Other interventions (Describe)

FINANCES/ECONOMIC STATUS/INSURANCE COVERAGE:

Describe the family's source of income or livelihood. Are the family's basic needs met? Does the family have difficulty meeting financial demands or are they burdened with significant medical debt? Does insurance cover health and related services needed to treat the client's chronic medical condition? Do immediate family members have health, dental or vision needs that cause a financial burden? (Describe)

Plan/Interventions: (Check all that apply)

- ☐ Provide client/family with information and counseling to help guide insurance-related decisions
- ☐ Provide information on other potential sources of healthcare coverage (e.g., Health Insurance Marketplace, www.healthcare.com)
- ☐ Help client/family coordinate insurance benefits between third-party payers
- ☐ Verify Medicaid eligibility-Explain Verification Method: _____
- ☐ Verify Healthy Steps (Up to age 19)
- ☐ Provide information about available insurance help-lines (e.g., Health coverage programs at 1-877-KIDS NOW or the ND Insurance Department at 800.247.0560)
- ☐ Provide family with a Healthcare Coverage Options Brochure www.ndhealth.gov/cshs
- ☐ Other interventions (Describe)

EDUCATION/TRAINING NEEDS:

Does the family or child need information about the child's medical condition? Has the family identified training needs or assistance with health care management? Is the child receiving special services in school (e.g., 504 Plan, IHP/ Individual Health Plan, IEP, etc.) Is the family interested in self-advocacy or leadership training opportunities? (Describe)	**Plan/Interventions: (Check all that apply)** ☐ Provide client/family with information on specific medical conditions (For resources, contact CSHS) ☐ Provide client/family with a care notebook (www.fvnd.org, click on Library, click on Publications 2, click on Recordkeeping/Care Notebook) ☐ Build Your Care Notebook www.medicalhomeinfo.org/for_families/care_notebook) ☐ Coordinate with school (e.g. school nurse or educational team) ☐ Other interventions (Describe)

PROBLEM SOLVING SKILLS, SUPPORT SYSTEMS AND COPING:

Is the family able to identify solutions to problems? Are informal or formal support systems present? How is the family coping with the client's condition? (Describe)	**Plan/Interventions: (Check all that apply)** ☐ Link family to various support options (e.g., Family Voices, ND Parent to Parent, Federation of Families, Pathfinder Family Center, condition-specific support groups, Sibshops, etc.) ☐ Offer suggestions and professional perspective to identify solutions to problems ☐ Refer for additional counseling (e.g., family crisis or grief counseling) ☐ Other interventions (Describe)

OTHER SOCIAL/EMOTIONAL FACTORS:

What strengths can the client/family identify? What is the client's/family's greatest priority or area of concern? Does the family need extra assistance to coordinate care? (Describe)	**Plan/Interventions: (Check all that apply)** ☐ Help client/family maintain contact or communication between multiple service providers, agencies and organizations involved in the client's care ☐ Help client/family remove barriers or gain skills necessary to follow through with treatment recommendations ☐ Address unique cultural considerations ☐ Other interventions (Describe)

TRANSITION (Required for clients ages 14 to 21):

Has the client/family developed a plan to help the client move from pediatric to adult healthcare? Does the client have a "portable" medical record or care plan? Is the youth or young adult familiar with his or her own specific condition and treatments? Has the client/family talked about necessary steps needed to transition from high school to work or college? Does the client plan on living independently after school? Will he/she need assistance living on his or her own? (Describe)	**Plan/Interventions: (Check all that apply)** ☐ Provide client/family with information to support transition from pediatric to adult health care, school to work, and home to independent living (For resources, contact CSHS) ☐ Encourage client independence (e.g., make own appointments, order medication refills, practice completing health related forms, etc.) ☐ Help client/family identify adult specialty providers ☐ Refer client to independent living center, vocational rehabilitation, college Disability Support Services, etc. ☐ Help client identify source of healthcare coverage if they no longer qualify under parents' policy ☐ Provide client with transition information www.gottransition.org ☐ Provide client with transition notebook (www.fvnd.org , click on Library, click on Publications 2, click on Transition Notebook for Youth) ☐ Refer to youth leadership opportunities ☐ Other interventions (Describe)

RESOURCE UTILIZATION:

Review services currently receiving. Assess whether a referral is needed and document who will make the contact.

Plan Interventions: (Check all that apply)

Service List	Currently Receives	Referral Made	Comments
Anne Carlsen	☐	☐	
Child Care Assistance	☐	☐	
Child Care Aware	☐	☐	
Child Support	☐	☐	
Community Health Centers	☐	☐	
Developmental Disabilities	☐	☐	
Drug/Alcohol Services	☐	☐	
Easter Seals Goodwill, Inc.	☐	☐	
Family Planning	☐	☐	
Family Voices	☐	☐	
Federation of Families	☐	☐	
Food Pantry	☐	☐	
General Assistance	☐	☐	
Genetic Counseling	☐	☐	
Head Start	☐	☐	
Health Tracks (EPSDT)	☐	☐	
Healthy Steps (CHIP)	☐	☐	
Home Health Care	☐	☐	
Housing Assistance	☐	☐	
Human Service Centers	☐	☐	
Independent Living Centers	☐	☐	
Infant Development (Early Intervention)	☐	☐	
Legal Aid	☐	☐	
LIHEAP (Fuel Assistance)	☐	☐	
Medicaid Waivers (ID/DD, Medically Fragile,	☐	☐	
HCBS, Autism, Children's Hospice)	☐	☐	
Medical Assistance (Medicaid)	☐	☐	
Mental Health Services	☐	☐	
North Dakota Association for the Disabled	☐	☐	
Oral Health Services (dental)	☐	☐	
OT/PT/Speech Therapy	☐	☐	
Parent Aid	☐	☐	
Parent to Parent	☐	☐	
Pathfinder Family Center	☐	☐	
Prescription Assistance Programs	☐	☐	
Project Carson (prenatal/at birth DX)	☐	☐	
Protection & Advocacy	☐	☐	
Public Health	☐	☐	
Reduced School Lunch	☐	☐	
Respite Care	☐	☐	
Right Track	☐	☐	
School Nursing	☐	☐	
Shriners	☐	☐	
SNAP (Food Stamps)	☐	☐	
Special Education (IEP, 504)	☐	☐	
Specialty/Multidisciplinary Clinic	☐	☐	
Supplemental Security Income (SSI)	☐	☐	
Support Groups	☐	☐	
Temporary Assistance for Needy Families (TANF)	☐	☐	
Vocational Rehabilitation	☐	☐	
Women, Infants and Children (WIC)	☐	☐	
Other interventions (Describe)	☐	☐	

MONITORING, EVALUATION, AND PLAN MODIFICATION:
Quarterly contacts with client/family to reassess needs, evaluate achievement of outcomes, and modify the annual care coordination plan.

Quarter One – Contact Date:	
Face-to-Face Visit Held: ☐ Home ☐ Office ☐ Other _____	Individuals Present: ☐ Parent(s) ☐ Client ☐ Other _____
Comments:	
Quarter Two – Contact Date:	
Comments:	
Quarter Three – Contact Date:	
Comments:	
Quarter Four – Contact Date:	
Comments:	

SIGNATURES:

Parent/Guardian or Client if Over 18:	Date:
CSSB Representative/Care Coordinator:	Date:

Distribution by County Social Service Board:
☐ CSSB/Care Coordinator ☐ CSHS
☐ Family/Client if over 18 ☐ Other _____