Print Form

Attachment I

California Children's Services
Final Transition Summary
EXIT INTERVIEW/SURVEY

- o **CCS File Copy**
- o **CCS Client COPY**

Client Name: _____ CCS #: _____

Date: _____

MEDICAL CARE

Primary Care Physician

Name: _____ Phone: _____

Address: _____Fax:_____

Dentist

Name: _____ Phone: _____

Address: _____

Special Care Treatment Center/Specialty Doctor/Service

Name/Specialty: _____ Phone: _____

Address: _____

Name/Specialty: _____ Phone: _____

Address: _____

Name/Specialty: _____ Phone: _____

Address: _____

Name/Specialty: _____ Phone: _____

Address: _____

Pharmacy

Name: _____ Phone: _____

Address: _____

California Children's Services
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Additional Information

OTHER SERVICES

	Contact Name	Phone / Website
❒ Rehab Services	_____	_____
❒ In-Home Support Services	_____	_____
❒ Transportation	_____	_____
❒ SSI/Financial Support	_____	_____
❒ Regional Center	_____	_____
❒ Health Insurance	_____	_____

EQUIPMENT/SUPPLIES

Item	Vendor Name	Phone	Date Provided
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Completed by: _____ Date: _____