Print Form

CALIFORNIA CHILDREN'S SERVICES
ADOLESCENT TRANSITION CONFERENCE (ATC)
ADOLESCENT TRANSITION HEALTH CARE PLAN

NAME: _____ **BIRTHDATE:** _____

DIAGNOSIS: _____ **CCS#** _____

16 yrs. ATC date _____

Primary Care Physician/Medical Home	Other case managing agency (s) Therapist
Name: Address: Dentist:	(County Name): yes no IHO: yes no IEP: yes no School District: yes no Caseworker: _____ Attendance: _____ Residence: _____

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: _____

18 yrs. ATC date _____

Primary Care Physician/Medical Home	Other case managing agency (s) Therapist
Name: Address: Dentist:	(County Name): yes no IHO: yes no IEP: yes no School District: yes no Caseworker: _____ Attendance: _____ Residence: _____

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: _____

20 yrs. ATC date _____

Primary Care Physician/Medical Home	Other case managing agency (s) Therapist
Name: Address: Dentist:	(County Name): yes no IHO: yes no IEP: yes no School District: yes no Caseworker: _____ Attendance: _____ Residence: _____

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
O_2 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

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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

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: