

The San Francisco Medical Home Project



Resources for Children with Special Health Care Needs and their Families

March 2012



**Lucile Packard
Children's Hospital
at Stanford**



**SUPPORT FOR FAMILIES
OF CHILDREN WITH DISABILITIES**

Medical Home activities are supported by Lucile Packard Children's Hospital,
Support for Families of Children with Disabilities, San Francisco County and San Francisco Foundation

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Adapted from the Alameda County Medical Home Project Binder by Anna Costalas,
Support for Families of Children with Disabilities (SFCD)

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The San Francisco County Medical Home Project March 2012

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San Francisco County Medical Home Project Introduction



There are many resources available for children with special health care needs (CSHCN) living in Alameda County; however, understanding the various service systems providing support can be a daunting task. Each program has its own regulations, eligibility requirements and funding streams.

Goal The goal of the San Francisco County Medical Home Project for Children with Special Health Care Needs Resource Guide is to aid providers and their staff in making appropriate referrals by providing a “snapshot” of each program, including:

- ◻ Eligibility requirements
- ◻ Services provided
- ◻ Application procedures
- ◻ Contact information for each resource

Guide Sections The Resource Guide is divided into eight sections. A digital version of each section will also be provided in portable document format (pdf) on the Resource Guide companion compact disc (CD).

- A) Health Services
- B) Mental Health Services
- C) Oral/Dental Health Services
- D) Family Assistance
- E) Family Support & Advocacy
- F) Educational & Developmental Services
- G) Transition to Adult Services
- H) Forms

The Medical Home The American Academy of Pediatrics (AAP) description of The Medical Home is included in this introduction. Making appropriate referrals is one of the ways in which providers and their staff can offer coordinated care consistent with the Medical Home model. A Medical Home is an approach to care to better meet the needs of children with special health care needs and their families. It is a way to provide health care for these children in a high quality and cost-effective manner. The basic components of a Medical Home include care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent.

We hope that this resource material will be useful to you and the families that you serve. If you have questions or comments, please contact us. We welcome your partnership in furthering the ideals and objectives of The Medical Home in our community.

Contact Information (510) 540-8293
(510) 540-8293 FAX

CRISS Project of Lucile Packard Children’s Hospital
Medical Home activities are supported by:
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Support for Families of Children with Disabilities
San Francisco County



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The Medical Home

The American Academy of Pediatrics (AAP) believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them. These characteristics define the “medical home.” In contrast to care provided in a medical home, care provided through emergency departments, walk-in clinics, and other urgent-care facilities, though sometimes necessary, is more costly and often less effective.”¹

The AAP
and the
Medical
Home

The following characteristics of a Medical Home have been developed by the Alameda County Medical Home Project from materials published by the AAP and the Center for Medical Home Improvement. These are intended to give primary care providers concrete actions that can be incorporated into their medical practices toward the goal of becoming a Medical Home for children with special health care needs (CSHCN).

¹American Academy of Pediatrics, “Policy Statement: The Medical Home,” *Pediatrics*, Vol. 110, No. 1, July 2002. pp. 184–186.

Contact (847) 434-4000
Information (847) 434-4000 FAX

email
Web site
AAP Policy site

National Center of Medical Home Initiatives
for Children with Special Needs
American Academy of Pediatrics
141 Northwest Point Blvd, Elk Grove Village, IL 60007
medical_home@aap.org
<http://www.medicalhomeinfo.org>
<http://aappolicy.aappublications.org>

(603)228-8111
(603)228-8344 FAX

Web site

Center for Medical Home Improvement (CMHI)
Crotched Mountain Foundation
18 Low Avenue, Ste. 1
Concord, NH 03301
<http://www.medicalhomeimprovement.org>

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Medical Home Characteristics

Characteristics
of a Medical
Home

Optimal Medical Home Characteristics	
Accessible	<ul style="list-style-type: none"> • All families have telephone access to and emergency care available from the practice, 24 hours a day, 7 days a week. • Evening and weekend appointments are available in the practice. • Practice is accessible by public transportation. • All families are informed that they have access to their child's record, facilitated by staff within 24–48 hours. • Children with special health care needs (CSHCN) are identified by either a marker on their charts or in the computer database. • Extra time for an office visit is scheduled for CSHCN. • Physical access, social needs and other visit accommodations are addressed at the visit and are documented for future encounters. • Staff ask about any new problems when scheduling appointments. Chart documentation is updated and staff are prepared ahead of time ensuring continuity of care.
Family-Centered	<ul style="list-style-type: none"> • The family is recognized as the principal caregiver and expert in their child's care, and youth are recognized as the experts in their own care. • Feedback from families of CSHCN regarding their perception of care is gathered through systematic methods (e.g. suggestion boxes, surveys, focus groups, or interviews) and there is a process for staff to review this feedback and to begin problem solving. • Staff meets regularly to gather staff input about practice improvement ideas specifically in the area of care and treatment for CSHCN. Efforts are made toward related changes and improvements.
Comprehensive	<ul style="list-style-type: none"> • The current social, emotional, educational, and health status of the child is assessed at each visit. • The team (including primary care provider (PCP), family, and staff) develops a plan of care for CSHCN which details visit schedules and communication strategies and home, school and community concerns. Practice back up/cross coverage providers are informed of these plans. • Families are referred to non-medical services in the community that meet their specific needs such as family support options, respite care, equipment vendors, or transportation. • Significant office knowledge is available about family and medical resources and insurance options. Assessment of family needs leads to supported use of resources and information to solve problems (Title V, SSI, Healthy Families). • The practice learns about issues and needs related to CSHCN from the local medical home coalition and professional publications and organizations. Providers incorporate new information into practice care activities.

SFCMHP
Characteristics
of a
Medical Home
(continued)

Optimal Medical Home Characteristics (continued)	
Continuous	<ul style="list-style-type: none"> • The practice includes both children and adolescents. • Providers utilize a flexible approach to “aging” and “aging out” so that maturing CSHCN may stay in the practice throughout various transitions and until an adult PCP is identified. • When a child is hospitalized, the provider or other practice staff meets with the discharge planning team to assist with the child’s transition back to the community.
Coordinated	<ul style="list-style-type: none"> • Families and youth are supported to play a central role in care coordination. • The PCP or other practice staff assists the family in setting up the specialty appointment and communicating the clinical issues to that specialist. Together, the PCP and the family agree on a point person for care coordination. • The PCP discusses the results of the specialty visit with the family and questions are answered. • Practice staff participates in the child’s IFSP or IEP process either by phone, letter or at the actual conference, if requested by family. • Practice maintains current electronic records to identify and quantify populations and to track selected health indicators and outcomes, including hospitalizations and emergency room visits.
Compassionate	<ul style="list-style-type: none"> • The practice actively takes into account the overall family impact when a child has a chronic health condition by considering all family members in the care plan. Staff will assist them to set up family support connections when families request it. • The practice informs the family of resources for support and advocacy and facilitates the connections; they advocate on a family’s behalf to solve specific problems pertinent to CSHCN.
Culturally Competent	<ul style="list-style-type: none"> • The practice provides a translator or interpreter for families who speak no English or who speak English as a second language. • The practice distributes materials that have been translated into the primary language the family uses. • A family’s beliefs, rituals, and customs are solicited and an attempt is made to incorporate them into the treatment plan.



Medical Home Acronyms

A	AAP	American Academy of Pediatrics
	ABA	Applied Behavioral Analysis
	ADA	Americans with Disabilities Act
	ADD	Attention Deficit Disorder
	ADHD	Attention Deficit Hyperactive Disorder
	AHTP	Adolescent Health Transition Project
	AIM	Access for Infants & Mothers Program
	ASD	Autism Spectrum Disorder
	ASL	American Sign Language
	ASQ	Ages and Stages Questionnaire
	AT	Assistive Technology
	AUT	Autism or Autism-like (IDEA disability category)
C	CalWORKS	California's Temporary Aid to Needy Families (TANF) program
	CASE	Community Alliance for Special Education
	CCS	California Children's Services
	CDE	California Department of Education
	CDI	CA Department of Insurance Consumer Communication Bureau
	CEC	Council for Exceptional Children
	CH	Communicatively Handicapped
	CHAMP	Children's Health Access and Medical Program
	CHDP	Child Health & Disability Prevention Program
	CHRCO	Children's Hospital Research Center at Oakland
	CIL	Center for Independent Living
	CMH	Community Mental Health
	CMS	Children's Medical Services
	COE	County Office of Education
	CSHCN	Children with Special Health Care Needs
	CPS	Child Protective Services
	CQI	Continuous Quality Improvement
D	DB	Deaf-Blindness (IDEA disability category)
	DD	Developmental Disability
	DDS	Department of Developmental Services
	DEAF	Deafness (IDEA disability category)
	DHHS	Department of Health and Human Services
	DIS	Designated Instruction and Services
	DMH	Department of Mental Health

E

DOB	Date of Birth
DOR	Department of Rehabilitation
DRC	Disability Rights California (formerly Protection & Advocacy - PAI)
DREDF	Disability Rights Education and Defense Fund
DSPS	Disabled Students Programs & Services
DSS	Department of Social Services
DX	Diagnosis

F

ED	Emotional Disturbance (IDEA disability category) see SED
EI	Early Intervention
EL or ELL	English Learner, or English Language Learner
EMD	Established Medical Disability (IDEA disability category - PreK)
EPSDT	Early & Periodic Screening, Diagnosis & Treatment
ERMHS	Educationally Related Mental Health Services

G

FAPE	Free & Appropriate Public Education
FEP	Fluent in English Proficiency
FI	Full Inclusion (special education program on placement continuum)
FIG	Federal Income Guidelines
FPL	Federal Poverty Level
FSP	Food Stamp Program

H

GHPP	Genetically Handicapped Persons Program
GGRC	Golden Gate Regional Centert

I

HCA	Health Consumer Alliance
HELP	Hawaii Early Learning Profile
HH	Hard of Hearing (IDEA disability category)
HH (also)	Home and Hospital (special education program on placement continuum)
HHS	Health and Human Services
HI	Hearing Impairment (IDEA disability category - Deaf and HH inclusive)
HMO	Health Maintenance Organization

K

IA	Instructional Aide (special education paraprofessional)
ID	Intellectual Disability (newer term for MR)
IDEA	Individuals with Disabilities Education Act (law providing special education)
IDP	Infant Development Program
IEP	Individualized Education Plan (special education plan for eligible students)
IFSP	Individualized Family Service Plan
IHSS	In-Home Supportive Services
IPP	Individual Program Plan (Regional Center plan for eligible individuals)

L

LCSW	Licensed Clinical Social Worker
LEA	Local Education Agency (School District)
LEP	Limited English Proficiency
LH	Learning Handicapped
LRE	Least Restrictive Environment (IDEA and Section 504 law guarantee)

M

M-CHAT	Modified Checklist for Autism in Toddlers
MCH	Maternal Child Health
MD	Multiple Disabilities (IDEA disability category)
MFCC	Masters in Family & Child Counseling
MHI	Medical Home Index
MI	Medically Indigent
MN	Medically Needy
MR	Mental Retardation (IDEA disability category) see ID
MTU	Medical Therapy Unit (CCS)

N

NHSP	Newborn Hearing Screening Program
NE	Natural Environment
NOA	Notice of Action (CCS)

O

OAH	Office of Administrative Hearings (special education Due Process)
OCR	Office for Civil Rights
OCRA	Office of Clients' Rights Advocacy
OH	Orthopedically Handicapped
OHI	Other Health Impairment (IDEA disability category)
OI	Orthopedic Impairment (IDEA disability category)
OSEP	Office of Special Education Programs (U.S. Dept. of Education)
OT	Occupational Therapy

P

PAI	see DRC
PCP	Primary Care Provider
PDD-NOS	Pervasive Developmental Disorder - Not Otherwise Specified
PEC	Parent Empowerment Centers
PEDS	Parents Evaluation of Developmental Status
PEDS:DM	PEDS Developmental Milestones
PHC	Public Health Clearinghouse
PHN	Public Health Nurse
PIAT	Peabody Individual Achievement Test
PP	Prevention Program (Regional Center)

P	PRRS	Early Start Prevention Resource and Referral Services
	PS	Program Specialist (special education school district administrator)
	PSRS	Procedural Safeguards Referral Service (special education compliance)
	PSS	Parental Stress Service (now FamilyPaths)
	PT	Physical Therapy
	PTI	Parent Training and Information center (help for students with disabilities 0-22)
R		
	RC	Regional Center
	ROCP	Regional Occupational Centers and Programs
	RSP	Resource Specialist Program (special education program on continuum)
S		
	SC	Service Coordinator (usually Regional Center)
	SDC	Special Day Class (special education program on placement continuum)
	SEC 504	Section 504 of the Rehabilitation Act (anti-discrimination / accommodations)
	SED	Serious Emotional Disturbance (see ED)
	SELPA	Special Education Local Plan Area (planning/oversight of LEAs/school districts)
	SFHP	San Francisco Health Plan
	SH	Severely Handicapped
	SHCN	Special Health Care Needs
	SLD	Specific Learning Disability (IDEA disability category)
	SLI	Solely Low Incidence [Disability] (hearing, visual, orthopedic impairments and deaf-blindness)
	SLI [also]	Speech and Language Impairment (IDEA disability category)
	SSA	Social Security Administration
	SSI	Supplemental Security Income
	ST	Speech Therapy
T	TANF	Temporary Assistance to Needy Families (CalWORKS; formerly AFDC)
	TBI	Traumatic Brain Injury (IDEA disability category)
U	UCP	United Cerebral Palsy
V		
	VH	Visually Handicapped
	VI	Visual Impairment (IDEA disability category)
W		
	WIC	Women, Infants and Children (Nutrition Program)
	WISC III	Wechsler Intelligence Scale for Children – III
	WJEB-R	Woodcock-Johnson Psychoeducational Battery - Revised
	WPPSI-R	Wechsler Pre-School & Primary Scale of Intelligence - Revised
	WRAT3	Wide Range Achievement Test – Revision 3

The Medical Home Index: Short Version (MHI-SV)

Measuring the Organization & Delivery of Primary Care
for Children with Special Health Care Needs

Center for
Medical Home
Improvement
(CMHI)

The Medical Home Index (MHI) is a nationally validated self-assessment tool designed to quantify the “medical homeness” of a primary care practice. Derived from the Center for Medical Home Improvement’s (CMHI) original Medical Home Index, this short version can be used as an interval measurement in conjunction with the original MHI or as a quick “report card” or snapshot of practice quality. CMHI recommends the use of the full MHI for practice improvement purposes but offers this short version for interval or periodic measurement and/or when it is not feasible to use the full MHI.

The full MHI contains twenty-five indicators which detail excellent, pro-active, comprehensive pediatric primary care. It functions both as a quality improvement tool and as a self education medium relevant to the medical home.

The Medical Home Index: Short Version (MHI-SV) is a brief representation of the more complete measurement tool. It scores a practice on a continuum of care across three levels:

- Level 1 = Good, responsive pediatric primary care
- Level 2 = Pro-active pediatric primary care (in addition to Level 1)
- Level 3 = Pediatric primary care at the most comprehensive levels
(in addition to Levels 1 and 2)

As the reporter for your entire practice and in response to each of the ten indicators, please score your medical home at:

- Level 1
- Level 2 partial
- Level 2 complete
- Level 3 partial
- Level 3 complete

Both the full 25-item Medical Home Index and the following 10-item MHI: Short Version can be downloaded from the CMHI website:

CMHI www.medicalhomeimprovement.org
Downloads www.medicalhomeimprovement.org/knowledge/practices.html

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Center for
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<i>Medical Home Index – Short Version (MHI-SV)</i>			
	<i>Level 1</i>	<i>Level 2</i> (in addition to level 1)	<i>Level 3</i> (in addition to level 2)
# 1 Family Feedback <i>Requires both MD & key non-MD staff person's perspective.</i> (# 1.5 MHI-Full Version)	Pediatric primary care without the elements detailed in levels 2 and 3. <input type="checkbox"/> Level 1	Feedback from families of <i>CSHCN</i> regarding their perception of care is gathered through systematic methods (e.g. surveys, focus groups, or interviews); there is a process for staff to review this feedback and to begin problem solving. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	An advisory process is in place with families of <i>CSHCN</i> which helps to identify needs and implement creative solutions; there are tangible supports to enable families to participate in these activities (e.g. childcare or parent stipends). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
# 2 Cultural Competence (# 1.6 MHI-FV)	Pediatric primary care without the elements detailed in levels 2 and 3. <input type="checkbox"/> Level 1	Materials are available and appropriate for non-English speaking families; those with limited literacy; these materials are appropriate to the developmental level of the child/young adult. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	Family assessments include pertinent cultural information, particularly about health beliefs; this information is incorporated into care plans; the <i>practice</i> uses these encounters to assess patient & community cultural needs. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
#3 Identification of Children in the Practice with Special Health Care Needs (# 2.1 MHI-FV)	Pediatric primary care without the elements detailed in levels 2 and 3. <input type="checkbox"/> Level 1	A <i>CSHCN</i> list is generated by applying a definition (see pg. 6), the list is used to enhance care +/- or define <i>practice</i> activities (e.g. to flag charts and computer databases for special attention or identify the population and its subgroups). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	Diagnostic codes for <i>CSHCN</i> are documented, problem lists are current, and complexity levels are assigned to each child; this information creates an accessible <i>practice</i> database. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE

<i>Medical Home Index – Short Version (MHI-SV)</i>			
	<i>Level 1</i>	<i>Level 2</i> (in addition to level 1)	<i>Level 3</i> (in addition to level 2)
#4 Care Continuity (# 2.2 MHI-FV)	Pediatric primary care without the elements detailed in levels 2 and 3. <input type="checkbox"/> Level 1	The team (including PCP , family, and staff) develops a plan of care for CSHCN which details visit schedules and communication strategies; home, school and community concerns are addressed in this plan. Practice back up/cross coverage providers are informed by these plans. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The practice /teams use condition protocols; they include goals, services, interventions and referral contacts. A designated care coordinator uses these tools and other standardized office processes which support children and families. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
#5 Cooperative Management Between Primary Care Provider (PCP) and Specialist (# 2.4 MHI-FV)	Pediatric primary care without the elements detailed in levels 2 and 3. <input type="checkbox"/> Level 1	The PCP and family set goals for referrals and communicate these to specialists; together they clarify co-management roles among family, PCP and specialists and determine how specialty feedback to the family and PCP is expressed, used, and shared. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The family has the option of using the practice in a strong coordinating role; parents as partners with the practice manage their child's care using specialists for consultations and information (unless they decide it is prudent for the specialist to manage the majority of their child's care). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE

Medical Home Index – Short Version (MHI-SV)			
	Level 1	Level 2 (in addition to level 1)	Level 3 (in addition to level 2)
#6 Supporting the Transition to Adulthood (# 2.5.1 MHI-FV)	<input type="checkbox"/> Level 1 Pediatric primary care without the elements detailed in levels 2 and 3.	Pediatric and adolescent PCPs support youth & family to manage their health using a transition timeline & developmental approach; they assess needs & offer culturally effective guidance related to: <ul style="list-style-type: none"> • health & wellness • education & vocational planning • guardianship and legal & financial issues • community supports & recreation When youth transition from pediatrician to adult provider: Pediatricians help to identify an adult PCP and sub-specialists and offer ongoing consultation to youth, family and providers during the transition process. Adult Providers offer an initial “welcome” visit and a review of transition goals.	Progressively from age 12, youth, family and PCP develop a written transition plan within the care plan; it is made available to families and all involved providers. Youth and families receive coordination support to link their health and transition plans with other relevant adolescent and adult providers/services/agencies (e.g. sub-specialists, educational, financial, insurance, housing, recreation employment and legal assistance).
#7 Care Coordination /Role Definition (# 3.1 MHI-FV)	<input type="checkbox"/> Level 1 Pediatric primary care without the elements detailed in levels 2 and 3.	<input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE Care coordination activities are based upon ongoing assessments of child and family needs; the <i>practice</i> partners with the family (and older child) to accomplish care coordination goals.	<input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE Practice staff offer a set of care coordination activities, their level of involvement fluctuates according to family needs/wishes. A designated care coordinator ensures the availability of these activities including written care plans with ongoing monitoring.



Center for
Medical Home
Improvement

Medical Home Index – Short Version (MHI-SV)			
	Level 1	Level 2 (in addition to level 1)	Level 3 (in addition to level 2)
#8 Assessment of Needs/ Plans of Care (# 3.4 MHI-FV)	Pediatric primary care without the elements detailed in levels 2 and 3. <input type="checkbox"/> Level 1	The child with special needs, family, and PCP review current child health status and anticipated problems or needs; they create/revise action plans and allocate responsibilities at least 2 times per year or at individualized intervals. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The PCP /staff and families create a written plan of care that is monitored at every visit; the office care coordinator is available to the child and family to implement, update and evaluate the care plan. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
#9 Community Assessment of Needs for CSHCN (# 4.1 MHI-FV)	Pediatric primary care without the elements detailed in levels 2 and 3. <input type="checkbox"/> Level 1	Providers raise their own questions regarding the population of CSHCN in their practice community(ies); they seek pertinent data and information from families and local/state sources and use data to inform practice care activities. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	At least one clinical practice provider participates in a community-based public health need assessment about CSHCN ; integrates results into practice policies, and shares conclusions about population needs with community & state agencies. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
#10 Quality Standards (structures) (# 6.1 MHI-FV)	Pediatric primary care without the elements detailed in levels 2 and 3. <input type="checkbox"/> Level 1	The practice has its own systematic quality improvement mechanism for CSHCN ; regular provider and staff meetings are used for input and discussions on how to improve care and treatment for this population. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The practice actively utilizes quality improvement (QI) processes; staff and parents of CSHCN are supported to participate in these QI activities; resulting quality standards are integrated into the operations of the practice . <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE

The Medical Home Index - Short Version: Measuring the Organization and Delivery of Primary Care for Children with Special Health Care Needs

DEFINITIONS OF CORE CONCEPTS (Words in italics throughout the document are defined below.)

Children with Special Health Care Needs (CSHCN):

Children with special health care needs are defined by the *US Maternal and Child Health Bureau* as those who have, or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally (USDHHS, MCHB, 1997).

Medical Home:

A medical home is a community-based primary care setting which provides and coordinates high quality, planned, family-centered health promotion and chronic condition management. According to the American Academy of Pediatrics (AAP) “medical home” is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.

Family-Centered Care (US Maternal and Child Health Bureau, 2004):

Family-Centered Care assures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-Centered Care is the standard of practice which results in high quality services.



The Medical Home Index – Short Version:

Measuring the Organization and Delivery of Primary Care for Children with Special Health Care Needs GLOSSARY OF TERMS (continued)

Care Coordination Activities:

Care and services performed in partnership with the family and providers by health professionals to:

- 1) Establish family-centered community-based “**Medical Homes**” for *CSHCN* and their families.
 - Make assessments and monitor child and family needs
 - Participate in parent/professional practice improvement activities
- 2) Facilitate timely access to the **Primary Care Provider (PCP)**, services and resources
 - Offer supportive services including counseling, education and listening
 - Facilitate communication among PCP, family and others
- 3) Build bridges among families and health, education and social services; promotes continuity of care
 - Develop, monitor, update and follow-up with care planning and care plans
 - Organize wrap around teams with families; support meeting recommendations and follow-up
- 4) Supply/provide access to referrals, information and education for families across systems.
 - Coordinate inter-organizationally
 - Advocate with and for the family (e.g. to school, daycare, or health care settings)
- 5) Maximize effective, efficient, and innovative use of existing resources
 - Find, coordinate and promote effective and efficient use of current resources
 - Monitor outcomes for child, family and practice

Chronic Condition Management (CCM):

CCM acknowledges that children and their families may require more than the usual well child, preventive care, and acute illness interventions.

CCM involves explicit changes in the roles of providers and office staff aimed at improving:

- 1) Access to needed services
- 2) Communication with specialists, schools, and other resources, and
- 3) Outcomes for children and families.

(The Medical Home Index – SV – Page 7)

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The Medical Home Index – Short Version: Measuring the Organization and Delivery of Primary Care for Children with Special Health Care Needs

GLOSSARY OF TERMS* (continued)

Quality:

Quality is best determined or judged by those who need or who use the services being offered. Quality in the medical home is best achieved when one learns what children with special health care needs and their families require for care and what they need for support. Health care teams in partnership with families then work together in ways which enhance the capacity of the family and the practice to meet these needs. Responsive care is designed in ways which incorporate family needs and suggestions. Those making practice improvements must hold a commitment to doing what needs to be done and agree to accomplish these goals in essential partnerships with families.

Office Policies

Definite courses of action adopted for expediency; “the way we do things”; these are clearly articulated to and understood by all who work in the office environment.

Practice:

The place, providers, and staff where the PCP offers pediatric care

Primary Care Provider - (PCP):

Physician or pediatric nurse practitioner who is considered the main provider of health care for the child

United States Maternal and Child Health Bureau - (USMCHB):

A division of Health Resources Services Administration

Requires both MD and key non-MD staff person’s perspective - you will see this declaration before select themes; the project has found that these questions require the input of both MD and non MD staff to best capture practice activity.

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Primary Health Services Programs

- * Health Services Overview Chart
- * Medi-Cal
- * Child Health and Disability Prevention (CHDP) Program
- * Healthy Families Program
- * Healthy Kids Programs
- * Kaiser Permanente Cares for Kids Child Health Plan
- * Access for Infants and Mothers (AIM) Program

Supplemental Health Services Programs

- * California Children Services (CCS)
- * Genetically Handicapped Persons Program (GHPP)
- * Newborn Hearing Screening Program (NHSP)
- * Nutrition Services
- * Women, Infants, and Children (WIC) Program

Income Limit Tables

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Health Services Overview

Regular health care is important for a child's well being and physical development. Here are a few programs that provide no-cost or low-cost healthcare for children.

Health Services Overview Chart Programs most used by children with special health care needs (CSHCN)	Medi-Cal	Child Health and Disability Prevention (CHDP) Program
	<p>Provides no-cost* comprehensive health, dental and vision coverage for children and pregnant women.</p> <p>Eligibility determined by family size, children's ages and family income.</p> <p>Available to eligible U.S. citizens, U.S. nationals or immigrants.</p> <p>*Families whose income is higher than the allowable limits for no-cost Medi-Cal will have a share of cost based on income and family size.</p> <p>(888) 747-1222 Information, toll free (415) 863-9892 Information</p>	<p>Provides no-cost well-child screening program for infants, children and teens. Any identified health problems are referred for diagnosis and treatment.</p> <p>Eligibility Those on Medi-Cal (birth up to age 21), or those (birth up to age 19) in families who have low-to-moderate income; up to 200% of the Federal Poverty Level (FPL).</p> <p>(415) 575-5712 CHDP San Francisco</p>
	Healthy Families Program	Kaiser Permanente Cares for Kids Child Health Plan
	<p>Provides low-cost health, dental and vision coverage for children who are not eligible for no-cost Medi-Cal.</p> <p>Cost \$13 to \$24 per child each month. Maximum \$72 per family; some co-pays.</p> <p>Eligibility determined by family size, children's ages and family income. Available to U.S. citizens, U.S. nationals and "qualified" immigrant children (under age 19) not eligible for no-cost Medi-Cal.</p> <p>(888) 747-1222 Information, toll free (800) 880-5305 Information</p>	<p>Provides low-cost health care coverage for uninsured children who are not eligible for no-cost Medi-Cal or Healthy Families.</p> <p>Available to children (under age 19) who live within Kaiser Permanente's California service area.</p> <p>Cost \$8 to \$15 per child per month. Maximum \$45 per family; some co-pays.</p> <p>Eligibility based on family size/income.</p> <p>(800) 464-400 Information/Request Enrollment Packet</p>
	Access for Infants and Mothers (AIM) Program	
	<p>Provides health insurance for uninsured pregnant women until 60 days after pregnancy has ended.</p> <p>Eligibility To qualify, women must be less than 31 weeks pregnant, CA residents for at least 6 months, not eligible for no-cost Medi-Cal, uninsured, and have incomes within AIM guidelines. Women with insurance with maternity deductibles or co-payments over \$500 may also qualify.</p> <p>Total Cost is 1.5% of family income from pregnancy through 60 days post-partum.</p> <p>(800) 433-2611 AIM/Healthy Families Info Line/Application request</p>	

Source (abridged) Children's Health Access and Medical Program Network (CHAMP)

Web site <http://www.champ-net.org> (for more information)

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Medi-Cal

Medi-Cal, California's Medicaid program, provides health insurance for low-income families and individuals who lack health insurance.

Medi-Cal is composed of a variety of programs to serve people who lack insurance. Some of the most commonly used forms of Medi-Cal include:

Commonly used forms of Medi-Cal

- ❑ Fee-for-Service Medi-Cal
- ❑ Medi-Cal Managed Care
- ❑ Share-of-Cost Medi-Cal
- ❑ Medi-Cal Waiver services
- ❑ Emergency Medi-Cal

Services What services are provided?

- ❑ Hospital inpatient care
- ❑ Outpatient care
- ❑ Skilled nursing care
- ❑ Equipment & supplies
- ❑ Therapy
- ❑ Doctor visits
- ❑ Laboratory tests
- ❑ X-rays
- ❑ Pharmaceuticals
- ❑ Medical transportation

Providers Where are services provided?

Services may be obtained from any physician, clinic or hospital that is a state-approved Medi-Cal provider.

Eligibility Who is eligible to receive Medi-Cal?

Individuals eligible for Medi-Cal typically fall in one of the following categories:

Federal Poverty Level (FPL) Programs [see Income Limit Tables in this section]

Pregnant women and children/youth in the following income categories generally are eligible for Medi-Cal:

- ❑ Pregnant women and infants in families with incomes at or below 200% of FPL
- ❑ Children aged 1–5 in families with incomes at or below 133% of FPL
- ❑ Children aged 6–19 in families with incomes at or below 100% of FPL

Public Assistance Recipients

Recipients of the following public assistance are eligible for Medi-Cal:

- ❑ CalWORKs (formerly AFDC, currently TANF) recipients
- ❑ Supplemental Security Income/State Supplemental Payment (SSI/SSP) recipients

Medically Needy/Medically Indigent

Persons not eligible under the categories above may be eligible under other Medi-Cal categories:

- ❑ Medically Needy (MN)—uninsured families/individuals who have incomes too high to qualify for cash assistance but who otherwise qualify for CalWORKs or SSI/SSP
- ❑ Medically Indigent (MI)—low-income pregnant women, children under 21, and some adults in long-term care who do not qualify for public assistance or as medically needy

Common Types of Medi-Cal Programs	
FFS Medi-Cal	Under Fee-for-Service (FFS) Medi-Cal, recipients receive health care from state approved providers on a fee-for-service basis. The client takes his/her Medi-Cal card to any Medi-Cal provider and receives services without going through a health plan. In Alameda County, people who receive Supplemental Security Income (SSI) or are in foster care receive fee-for-service Medi-Cal and may receive services from any Medi-Cal approved provider. (People on SSI and children in foster care also may voluntarily choose to enroll in one of the two Medi-Cal managed care plans.)
Medi-Cal Managed Care	Medi-Cal has a managed care program under which state-approved health plans are paid a set monthly amount (capitation) to provide care to Medi-Cal recipients. Health plans then make agreements with providers to serve Medi-Cal recipients. Services may be obtained from any provider who is state-approved as a Medi-Cal provider and registered with one of the approved health plans. In San Francisco County, the plans are SF Health Plan, Anthem HMO, SF Blue Shield HMO, Health net HMO and Kaiser Permanente.
Share-of-Cost Medi-Cal	Share-of-Cost Medi-Cal offers health care coverage to individuals and families who have incomes too high to qualify for regular Medi-Cal, but too low to cover health care costs. Medi-Cal requires these recipients to contribute to their health care by paying a share of the cost for the services they receive. "Share of Cost" is a term that refers to the amount of health care expenses a recipient must accumulate each month before Medi-Cal begins to offer assistance. Share of cost is an amount that is owed to the provider of health care services, not to the state.
Medi-Cal Waiver Services	A Federal Waiver allows the state to disregard portions of the Social Security Act and provide Medi-Cal to individuals who may not otherwise be eligible. One type of waiver, 1915(c), also known as a "Katie Beckett Waiver," is limited in scope and allows exceptions to some federal requirements in order to provide home and community based services as an alternative to institutionalization. For example, under this type of waiver, a child with special health care needs may obtain Medi-Cal in order to receive health services that allow the child to remain at home instead of in a hospital or institution.
Emergency Medi-Cal	In some cases, individuals who would otherwise be ineligible for Medi-Cal due to immigration or other restrictions may apply for Medi-Cal Emergency Services. Emergency Medi-Cal use is restricted to only those services that meet the state definition of "emergency".

Enrollment

How does one enroll in Medi-Cal?

Enrollment in Medi-Cal can begin in-person at county offices or other locations, by mail, or over the phone.

For example, an applicant may go to the county social services office or meet with an eligibility worker who is “outstationed” at a community-based organization or health facility. The eligibility worker assists in filling out the application forms and collects documentation (such as proof of household address and income). Because of a federal rule change, applicants who are citizens, including most children (some groups, such as children in foster care, are exempt), also must provide documentation of their citizenship status.

Application information is electronically submitted to the state where crosschecks are conducted to verify reported income and other information provided. Applicants are notified by mail of their status (enrolled or declined) within 45 days of application.

Regardless of the method of enrollment, applicants will need to submit annual reports on their income and assets, subject to state rules in order to retain their Medi-Cal coverage. Applicants for Medi-Cal will be asked to provide their Social Security Numbers (parents/guardians of applicant children do not have to provide their Social Security Numbers).

Contact Information	(888) 747-1222	For Certified Application Assistants (to find in your area) Toll Free Information Line for Medi-Cal/Healthy Families
	(800) 880-5305	Healthy Families Toll-free To apply over the phone or to request a mail-in application
	(415) 863-9892	Medi-Cal Health Connections Office To request an application
Web sites	http://www.benefitscalwin.org http://www.medi-cal.ca.gov	

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Child Health and Disability Prevention (CHDP) Program



Child Health and Disability Prevention (CHDP) is a preventive, well-child screening program for infants, children and teens on Medi-Cal (birth up to age 21), or children (birth up to age 19) who have low to moderate income of up to 200% of the Federal Poverty Level (FPL). [see Income Limit Tables in this section] Through CHDP, children and youth can obtain regular, preventive health assessments to identify any health problems. Those with suspected problems are then referred for necessary diagnosis and treatment.

Services Health assessment services are provided, including:

- Q Health and developmental history
- Q Physical examination
- Q Nutritional assessment
- Q Immunizations
- Q Vision testing
- Q Hearing testing
- Q Lead testing
- Q Some laboratory tests
(e.g., tuberculin, sickle cell, urinalysis, hemoglobin/hematocrit, Pap smears)
- Q Health education and anticipatory guidance.
- Q Camp and sports physicals.
- Q Referrals to dentists who accept Medi-Cal
(Medi-Cal eligible children 3 years of age and over)
- Q Case management:
CHDP will assist families in obtaining diagnostic and treatment services.

Providers Where are services provided?

Private physicians, county health departments, clinics, and some local school districts provide CHDP health assessments. CHDP encourages private provider participation.

Eligibility Who is eligible?

- Q Medi-Cal beneficiaries (birth up to age 21) under the regulations of the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
- Q Non-Medi-Cal eligible children (birth up to age 19) from low-income families
- Q Children in Head Start and State Preschool programs are eligible for regular assessment while in these programs (generally ages 3 up to age 6)

Contact Information (415) 575-5712
(415) 558-5905 FAX

SF County CHDP
30 Van Ness Avenue, Suite 210
San Francisco, CA 94102

Web site <http://www.dhcs.ca.gov/services/chdp>

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Healthy Families Program



Healthy Families (California's State Children's Health Insurance Program) is funded by the state and federal governments to provide health benefits for children of low-income families who do not qualify for no-cost Medi-Cal and do not have access to private insurance.

Benefits/ Costs Healthy Families provides a commercial benefits package—modeled after state employee benefits—and requires co-payments, premium contributions and high-risk-condition carve-outs. Premiums range from \$13–24 per child per month, depending on the plan chosen, to a maximum of \$72 per month. There is a \$10–15 co-payment for most non-preventive services, including emergency room visits, and a \$250 annual co-payment maximum. No co-payment is required for routine preventive care visits.

Services What services are provided?

- Q Physician, medical and surgical services
- Q Inpatient and outpatient services
- Q Prescriptions
- Q Well-baby and well-child care
- Q Mental health services
- Q Occupational, physical and speech therapies
- Q Lab and X-ray services
- Q Dental benefits, including preventive and diagnostic services
- Q Vision coverage, including annual exams and eyeglasses
- Q Optional acupuncture and chiropractic care

Eligibility Who is eligible?

- Q Children from 0 up to 19 years of age under 250% of the federal poverty level (FPL) who are not eligible for no-cost Medi-Cal [see Income Limit Tables in this section]
- Q Children without employer-sponsored coverage during the last 3 months, unless that coverage was lost for reasons unrelated to Healthy Families
- Q Non-citizen, legal immigrant children who meet other eligibility criteria
- Q Children must be California residents

Enrollment How do you enroll?

- Q Application forms are available online at <http://www.healthyfamilies.ca.gov> or by phone at (800) 880-5305.
- Q Many organizations—including schools and welfare offices—also distribute enrollment forms.
- Q Information packets are available in a variety of languages.

Contact Information (888) 747-1222 Toll Free - Information Line
(800) 880-5305 Healthy Families CAA

Web site <http://www.healthyfamilies.ca.gov>

Healthy Kids Program

H **healthy Kids Program** provides medical, dental, and vision coverage for eligible children 0-18 years old.

Services What services are provided?

- Q Doctors visits
- Q Dental care
- Q Vision care
- Q Prescription Drugs
- Q Ob/GYN services
- Q Speciality care
- Q Hospital & Emergency Room
- Q Regular check ups & Immunizations
- Q Pregnancy care
- Q Family planning
- Q Substance Abuse Programs
- Q Mental Health services

Eligibility Who is eligible?

- Q Uninsured & under 19 years of age.
- Q San Francisco residents, US citizens, nationals, eligible qualified immigrants or undocumented immigrants.
- Q Not eligible for no-cost, full scope Medi-Cal or the Healthy Families Program.
- Q Within the guidelines.

Benefits-Costs Depending on income and family size, Healthy Kids members pay either \$48 to \$189 a year. Financial Assistance is available.

Enrollment Appointments are required:

phone: **(415) 777-9992**
(888) 558-5858
 email: enrollment@sfhp.org
 website: www.sfhp.org/visitors/programs/healthy_kids/

Contact phone: **(415) 547-7518**
Main Office fax: **(415) 547-7826**

Kaiser Permanente Cares for Kids Child Health Plan



Kaaiser Permanente Child Health Plan provides **comprehensive preventive, primary and specialty health care coverage** for children in families with low to moderate incomes who do not qualify for other public or private programs. Kaiser Permanente Child Health Plan services are provided in Kaiser Permanente medical offices and hospitals.

Services What services are provided?

- Q Medical office visits
- Q Hospital services
- Q Lab tests/X-rays
- Q Vision care
- Q Hearing and vision tests
- Q Prescription drugs
- Q Mental health services
- Q Substance abuse services
- Q Dental coverage
- Q Health education

Kaiser Permanente Child Health Plan **does not** cover:

- Q Chiropractic services
- Q Contact lens examination, fitting and dispensing
- Q Refractive eye surgery

Eligibility Who is eligible?

- Q Uninsured children (birth up to age 19) from families with incomes above 250% of the Federal Poverty Level (FPL) through 300% FPL, who are not enrolled in other public/private programs, such as Medi-Cal or Healthy Families, and are not eligible for employer-subsidized coverage [see Income Limit Tables]
- Q Children must live within the Kaiser Permanent California Division Service Area
- Q Resources (the things you own) do not count in this program
- Q Children's social security numbers are **requested but not required** on the application

Cost What does it cost?

- Q Premiums are \$8 to \$15 per child per month
- Q A family pays for only up to 3 children per family, or a maximum of \$45 per month; no premiums are paid for additional children in the family.
- Q There are co-payments for some services
(limit is \$250 for one child or \$500 for two children or more)

Enrollment How does a child receive Kaiser Permanente Child Health Plan services?

- Q Mail in application
(see phone number and website below to request application)

Contact Information (800) 255-5053 **Request an enrollment packet**
(800) 777-1370 TTY **Kaiser Permanente Child Health Plan**

Web site <https://info.kp.org/childhealthplan/overview.html>

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Access for Infants and Mothers (AIM) Program

Access for Infants and Mothers (AIM) provides low-cost health coverage for pregnant women and access to Healthy Families coverage for their newborns (up to age 2). It is designed for families in the middle income bracket who do not have health insurance and whose income is too high to qualify for no-cost Medi-Cal. AIM is also available to those who have health insurance, but only if the maternity-only deductible or co-payment is more than \$500. If a pregnant woman qualifies for AIM, her baby automatically qualifies for enrollment in the Healthy Families Program (see Healthy Families program in this section, page A-9).

Services What services are provided?

All medically necessary services are covered from the time of acceptance into the AIM Program until 60 days after the pregnancy has ended. Services include:

- Q All necessary physician visits
- Q Maternity care
- Q Prescriptions
- Q Diagnostic testing
- Q Health education
- Q Medical equipment charges
- Q Hospital services
- Q Skilled nursing
- Q Emergency services
- Q Mental health

Providers The State of California contracts with many health plans throughout the state. Plans then contract with provider groups and providers in the community.

Eligibility Who is eligible?

- Q Pregnant women (not more than 30 weeks)
- Q Must have lived in California for the last 6 months
- Q Cannot be receiving no-cost Medi-Cal or Medicare benefits
- Q Cannot have maternity benefits through private insurance, unless coverage has a separate maternity-only deductible or co-payment that is more than \$500
- Q Annual family income within the AIM income guidelines (200-300% of Federal Poverty Level) [see Income Limit Tables in this section]
- Q Newborns are eligible for Healthy Families Program (up to age 2) and with family incomes up to 300% of FPL (as opposed to the standard Healthy Families income eligibility of 250% of FPL)

Cost The total cost of AIM enrollment is 1.5% of the family's income after allowable income deductions; there are no co-payments or deductibles. Payment may be made when the application is submitted, or in monthly payments over one year. This payment covers care during pregnancy and 60 days of post-partum care.

Cancellation If AIM is cancelled on or after the first day of coverage (because of miscarriage or other reasons), the enrolled woman is still responsible for the full payment of 1.5% of the family's income.

Enrollment Download mail-in application online from the AIM website, or call for application.

Contact Information (800) 433-2611

Web site

AIM Program
P.O. Box 15559, Sacramento, CA 95852-0559
<http://www.aim.ca.gov>

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California Children Services (CCS)



California Children Services (CCS) is a program that pays for specialty health care services for eligible children/young adults with serious and/or chronic medical conditions.

Medical Conditions What are some examples of eligible conditions?
 ☐ Birth defects ☐ Blood disorders ☐ Cancer & some other tumors ☐ Cerebral palsy
 ☐ Endocrine & Metabolic disorders ☐ Genetic conditions ☐ Heart disease ☐ HIV/AIDS

Services What is the scope of CCS services?

Diagnostic Evaluations

The program pays for diagnostic evaluations necessary to determine whether a condition is medically eligible. CCS also covers HIV testing.

Treatment Services

CCS may authorize ongoing medical treatment and services such as:

- ☐ Hospitalizations and Surgeries
- ☐ Social services including case management
- ☐ Nutritional consultations
- ☐ Equipment/supplies/medications
- ☐ Orthodontics

Therapy Services

Physician and occupational therapy services are provided at Medical Therapy Units (MTUs) located on public school campuses to children with a physical disability who meet medical eligibility criteria.

Eligibility Who is eligible?

The program is open to anyone who meets **all** of the following requirements:

- ☐ Is under 21 years old
- ☐ Has or may have a medical condition that is covered by CCS
- ☐ Is a resident of California, **and**
- ☐ Has a family income of less than \$40,000 as reported as the adjusted gross income on the state tax form, **or**
- ☐ The out-of-pocket medical expenses for a child who qualifies are expected to be more than 20% of family income, **or**
- ☐ The child has Healthy Families coverage **or** Medi-Cal coverage

Eligibility Exceptions Family income is **not** a factor for children who:

- ☐ Need diagnostic services to confirm a CCS eligible medical condition, **or**
- ☐ Were adopted with a known CCS eligible medical condition, **or**
- ☐ Are applying only for services through the Medical Therapy Program, **or**
- ☐ Have Medi-Cal full scope, no share of cost, **or**
- ☐ Have Healthy Families coverage.

Providers Who are CCS providers?

CCS providers are health care professionals with special expertise in the treatment of children, such as Pediatricians, Neurologists, Orthopedists, Cardiologists, Orthodontists, Therapists, Social Workers, Nutritionists, Pharmacists and others. These providers must meet the participating standards and be approved by the State CCS program, to be on the CCS panel. Providers sometimes work together as a team to provide comprehensive care for children with certain conditions. Team services are usually provided in Special Care Centers.

Referral How does a child receive CCS Services?

Referrals may be made by anyone such as a family member, school staff, or health care provider. A referral may be sent on a **CCS Referral Form or in a letter** (please see forms section) which includes all the following information:

- Q Patient's name
- Q Date of Birth
- Q Medi-Cal number (if available)
- Q Name, address and telephone number of parent/legal guardian
- Q Address and telephone number of the child
- Q Medical condition
- Q Name, address and telephone number of the referral source

Application After a referral is made, a **CCS Application** will be sent or given to the family and must be completed by the parent or legal guardian. The application **must** be accompanied or followed by a medical report by the doctor. When the completed CCS application and medical report is received, the eligibility process begins.

Possible Fees The family must provide the financial and residential information needed to determine program eligibility. Some families may be required to pay an annual \$20 assessment fee and/or an annual enrollment fee based upon family size and earnings above a certain income.

Appeals What appeals process is in place?

Once a client has applied for CCS Services, they will receive a written decision if their eligibility or a service has been denied, reduced or stopped. This decision is called a **"Notice of Action"** (NOA). If the client does not agree with the decision, they may call CCS at the number listed on the NOA and attempt to resolve the issue by telephone. If this is unsuccessful, and the client is still interested in appealing, there is an official appeals process. The appeal process has two parts: FIRST LEVEL APPEAL and, if the client disagrees with the results, a FAIR HEARING. Both parts require written requests.

2nd Opinion When a CCS-approved doctor will not prescribe or refuses to continue prescribing a service, this does not fall under the formal appeals process. If this happens, the client may request a second opinion from an expert physician. This parent/caregiver will be able to choose the doctor from a list of three experts that CCS will provide. The opinion of the expert is final.

Contact Information (415) 575-5700
(415) 575-5790 FAX

California Children Services (CCS)
SF Department of Public Health
30 Van Ness Avenue
San Francisco, CA 94102

Web site <http://www.dhcs.ca.gov/services/ccs>

Genetically Handicapped Persons Program (GHPP)



Genetically Handicapped Persons Program (GHPP) is a state program that provides medical case management and pays the medical and dental costs of persons with certain genetic diseases including cystic fibrosis, hemophilia, sickle cell diseases and various neurological and metabolic diseases.

Services What services are provided?

The program provides medical treatment and case management services for persons ineligible for Medi-Cal and case management services for Medi-Cal-eligible beneficiaries with GHPP-eligible conditions.

Eligibility Who is eligible?

Persons aged 21 and over with one of the following genetic conditions who are partially or wholly unable to pay for care:

- Q Hemophilia and other genetic coagulation defects
- Q Cystic Fibrosis
- Q Sickle Cell Disease including Thalassemia
- Q Huntington's Disease
- Q Joseph's Disease
- Q Friedreich's Ataxia
- Q von Hippel-Lindau Disease
- Q Inborn Errors of Metabolism including disorders of amino-acid transport and metabolism such as Phenylketonuria (PKU)
- Q Disorders of carbohydrate transport and metabolism such as Galactosemia
- Q Disorders of copper metabolism such as Wilson's Disease

Eligibility Exception Persons under age 21 with one of the above genetic conditions may also be eligible for GHPP if they have first been determined to be financially ineligible to receive services from the CCS program.

Enrollment Referral and application forms are available on-line at the GHPP web site and may be completed and mailed to GHPP at the mailing address below.

Contact Information (800) 639-0597 **GHPP Information Line (Toll Free)**
 (916) 327-0470 (messages may be left for call-back)
 (916) 327-1112 FAX
 (916) 327-0670 FAX

Physical Address Genetically Handicapped Persons Program (GHPP)
 1515 K Street, Ste. 400
 Sacramento, CA 95899-7413

Mailing Address Genetically Handicapped Persons Program (GHPP)
 MS 8100
 P.O. Box 997413
 Sacramento, CA 95899-7413

Web site www.dhcs.ca.gov/services/ghpp (Apply online)

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Newborn Hearing Screening Program (NHSP)



Newborn Hearing Screening Program (NHSP) provides a comprehensive coordinated system of early identification and provision of appropriate services for infants with hearing loss.

Services The California NHSP provides:

- Q Parents of approximately 400,000 infants the opportunity to have their newborn babies screened for hearing loss at the time of the hospitalization for birth
- Q Tracking and monitoring of up to 25,000 infants to assure that appropriate follow-up testing and diagnostic evaluations are completed
- Q Access to medical treatment and other appropriate educational and support services.
- Q Coordinated care through collaboration with those agencies delivering early intervention services to infants and their families

Incidence The incidence of permanent significant hearing loss is approximately 2–4 per every 1000 infants. It is the most common congenital condition for which there is a screening program. It is estimated that the Newborn Hearing Screening Program will identify 1200 infants with hearing loss each year.

Program Focus The major focus of the program is to assure that every infant, who does not pass a hearing test, is linked quickly and efficiently with the appropriate diagnostic and treatment services and with the other intervention services needed for the best possible outcome. Recent research shows infants with hearing loss, who have appropriate diagnosis, treatment and early intervention services initiated before six months of age, are likely to develop normal language and communication skills.

Program Components The California Newborn Hearing Screening Program has two major components:

Q Screening

All CCS-approved hospitals will offer hearing screenings to all newborns born in their hospitals and will perform hearing screenings on all infants receiving care in a CCS-approved neonatal intensive care unit (NICU) prior to the infant's discharge.

Q Geographically-Based Hearing Coordination Centers

Each Center will be responsible for a specified geographic area. The functions of the Centers include:

- Assisting hospitals to develop and implement their screening programs
- Certifying hospitals to participate as screening sites
- Monitoring programs of the participating hospitals
- Assuring that infants with abnormal hearing screenings receive necessary follow-up, including rescreening, diagnostic evaluation, treatment, and referral to early intervention service agencies, as appropriate, providing information to families and providers so they can more effectively advocate with commercial health plans to access appropriate treatment.

Contact Information	(877) 388-5301	Toll-free information for Providers/Families
Physical Address	Newborn Hearing Screening Program 1515 K Street, Ste. 400 Sacramento, CA 95899-7413	
Mailing Address	Newborn Hearing Screening Program MS 8103 P.O. Box 997413 Sacramento, CA 95899-7413	
email	nhsp3@dhs.ca.gov	
Web site	www.dhcs.ca.gov/services/nhsp	

San Francisco County Outpatient Hearing Screening Providers (CCS Approved)

Provider Contact Information	Infant Screening and Hearing Services (ages 0 up to 21)	
	(415) 833-8222 (415) 833-8444 - fax	Kaiser Permanente 4141 Geary Blvd., 1st Floor San Francisco, CA 94118
	(415) 921-7658 (415) 921-2243 - fax	SF Hearing & Speech Center 1234 Divisadero Street San Francisco, CA 94115
	(415) 362- 5443 (415) 362- 2429 - fax	SF Otolaryngology Medical Group 450 Sutter Street, Suite 933 San Francisco, CA 94107
	Diagnostic Testing and Hearing Services only (ages 5 up to 21)	
	(415) 353-2101 (415) 353-2883 - fax	UCSF Audiology Clinic 233 Post Street, Suite 270 Campus Box 0340 San Francisco, CA 94108



Nutrition Services

Good nutrition is necessary to promote optimal growth and development. Children and youth with special health care needs are at high risk for nutrition-related problems. Nutrition screening is critical to identify problems early and prevent the adverse effects of malnutrition on growth and mental development. Nutrition screening is routinely conducted by many government-funded programs. If a nutrition concern is identified, a referral to a Registered Dietitian (RD) for nutrition assessment and medical nutrition therapy is recommended. Eligibility is often based on the child's diagnosis and family income.

Services What Nutrition Services are provided by the following agencies and programs?

California Children Services (CCS)

RDs on some Special Care Center multidisciplinary teams

Provide comprehensive nutrition assessment and intervention.

Follow-up visits can be authorized by CCS if Special Care Center Team Director lists in the team plan and approval is granted.

RDs in CCS Medical Therapy Program (school-based)

Upon referral by the CCS Medical Consultant, children who receive medical management from CCS can be assessed by a CCS nutrition consultant and receive nutrition intervention and follow-up care.

Child Health and Disability Prevention Program (CHDP)

If nutrition screening identifies a nutrition concern, the provider can refer for nutrition services to an RD who can bill under Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services or Medi-Cal.

Regional Center of the East Bay (RCEB)

Has RD vendors for nutrition assessment, intervention and follow-up services. (Regional Center is payer of last resort.)

Medi-Cal Managed Care Plan

Plan partners employ or contract with RDs for nutrition assessment and intervention. This requires a referral from primary care provider.

Dietitians in private practice

American Dietetic Association/Find a Registered Dietician Program provides an on-line list of dietitians in the community. Payment varies by individual dietitian.

Women, Infants & Children (WIC) Program

See complete information about WIC nutrition services in this section of binder.

Contact Information (415) 575-5700
(415) 575-5712
(415) 546-9222
(415) 863-9892
(888) 942-9675

California Children Services (CCS)
CHDP San Francisco County
Golden Gate Regional Center
Medi-Cal
WIC toll-free Information Line

Web site

American Dietetic Association - Find a Registered Dietician
<http://www.eatright.org> Click on "Find a RD" button

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Women, Infants & Children (WIC) Program



WIC is a supplemental food and nutrition education program that serves low-income pregnant, breastfeeding and postpartum women, and infants and young children who are at nutritional risk. The WIC Program provides nutritious foods, information on healthy eating, and referrals to health care to prevent health problems and improve the health of program participants during critical times of growth and development.

Citizenship is not necessary to qualify. The WIC Program is 100% federally funded through the U.S. Department of Agriculture (USDA). WIC is not an entitlement program, but a federal grant program for which Congress authorizes a specific amount of funds each year; funds are not set aside to allow every eligible individual to participate in the program.

Services What services are provided?

- Q Nutrition education and counseling at WIC clinics
- Q Screening and referrals to other health, welfare, and social services
- Q Supplemental nutritious foods and vouchers for selected foods
- Q Assistance with breastfeeding, including breast pumps
- Q Facilitation of access to special formulas for children with special needs

Eligibility Who is eligible?

An individual or family must have income at or below 185% of the federal poverty level (FPL). Women and children are automatically financially eligible if receiving Medi-Cal or TANF. In addition, the person must reside in the local agency's geographic service area and be nutritionally at-risk as determined by a health professional. The individual must be categorically eligible as a:

- Q Pregnant woman
- Q Woman post-partum to six months after delivery
- Q Breastfeeding woman up to 1 year after childbirth
- Q Postpartum woman up to 6 months after childbirth
- Q Infant (0 up to age 1)
- Q Child (1 up to age 5) at nutritional or medical risk

Contact Information (888) WIC-WORKS/ (888) 942-9675
(415) 575-5788 **WIC California toll-free Information Line**
WIC San Francisco County

Addresses

- Q **SF General Hospital Clinic**
2550 - 23rd Street, Building 9, Room 125, SF
- Q **Silver Avenue Family Health Center WIC Clinic**
1525 Silver Avenue, SF
- Q **Chinatown Public Health Center WIC Clinic**
1490 Mason Street, SF
- Q **Ocean Park Center WIC Clinic**
1351 24th Avenue, SF
- Q **South East Health Center WIC Clinic**
2401 Keith Street, SF

Web site <http://www.wicworks.ca.gov>

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Income Limit Tables (correct as of April 2012)

NOTE: All program income eligibility is subject to change, based on annual updates of the Federal Poverty Level and other factors.

Federal Poverty Level (FPL), also known as **Federal Income Guideline (FIG)**, is the amount of income the federal government says a family requires to meet its basic needs. If family size (number of persons in family) exceeds the family size shown, please call the respective program for more information. This figure is updated annually.

Federal Poverty Guidelines

Family Size	2011 Federal Poverty Level for the 48 Contiguous States and District of Columbia (DC)
1	\$ 10,890
2	\$ 14,710
3	\$ 18,530
4	\$ 22,350
5	\$ 26,170
6	\$ 29,990
7	\$ 33,810
8	\$ 37,630
Add'l	Add \$3,820 for each additional person in the family.
Source: http://aspe.hhs.gov/poverty/11poverty.shtml	

Medi-Cal

Family Size	Children 0 up to age 1 and Pregnant Women*	Children 1 up to age 6	Children 6 up to age 19
	Annual Income Not Over 200% FPL	Annual Income Not Over 133% FPL	Annual Income Not Over 100% FPL
1	\$ 21,660	\$ 14,404	\$ 10,830
2 *	\$ 29,140	\$ 19,378	\$ 14,570
3	\$ 36,620	\$ 24,352	\$ 18,310
4	\$ 44,100	\$ 29,327	\$ 22,050
5	\$ 51,580	\$ 34,301	\$ 25,790
6	\$ 59,060	\$ 39,275	\$ 29,530
7	\$ 66,540	\$ 44,249	\$ 33,270
* A pregnant woman counts as a family of two.			

Child Health and Disability Prevention (CHDP)

Family Size	Children 0 up to age 19 Annual Income Not Over 200% FPL	Children 0 up to age 19 Monthly Income Not Over 200% FPL
1	\$ 21,660	\$ 1,805
2	\$ 29,140	\$ 2,429
3	\$ 36,620	\$ 3,052
4	\$ 44,100	\$ 3,675
5	\$ 51,580	\$ 4,299
6	\$ 59,060	\$ 4,922
7	\$ 66,540	\$ 5,545

Healthy Families

Family Size	Children 0 up to age 1 Household Monthly Income	Children 1 up to age 6 Household Monthly Income	Children 6 up to age 19 Household Monthly Income
1	\$ 1,806 to \$ 2,257	\$ 1,202 to \$ 2,257	\$ 904 to \$ 2,257
2 *	\$ 2,430 to \$ 3,036	\$ 1,616 to \$ 3,036	\$ 1,216 to \$ 3,036
3	\$ 3,053 to \$ 3,815	\$ 2,031 to \$ 3,815	\$ 1,527 to \$ 3,815
4	\$ 3,676 to \$ 4,594	\$ 2,445 to \$ 4,594	\$ 1,839 to \$ 4,594
5	\$ 4,300 to \$ 5,373	\$ 2,860 to \$ 5,373	\$ 2,151 to \$ 5,373
6	\$ 4,923 to \$ 6,153	\$ 3,274 to \$ 6,153	\$ 2,462 to \$ 6,153
7	\$ 5,546 to \$ 6,932	\$ 3,689 to \$ 6,932	\$ 2,774 to \$ 6,932
Add'l	Add \$ 625 to \$ 780	Add \$ 416 to \$ 780	Add \$ 313 to \$ 780
* A pregnant woman counts as a family of two.			
Source: http://www.healthyfamilies.ca.gov/HFProgram/Income_Guidelines.aspx			

Kaiser Permanente Cares for Kids / Child Health Plan

Subject to change

Family Size parent + child	\$8 Monthly Premium per child * Annual Income before taxes	\$15 Monthly Premium per child * Annual Income before taxes
1	\$ 0 to \$ 27,075	\$ 27,076 to \$ 32,490
2	\$ 0 to \$ 36,425	\$ 36,426 to \$ 43,710
3	\$ 0 to \$ 45,775	\$ 45,776 to \$ 54,930
4	\$ 0 to \$ 55,125	\$ 55,126 to \$ 66,150
5	\$ 0 to \$ 64,475	\$ 64,476 to \$ 77,370
6	\$ 0 to \$ 73,825	\$ 73,826 to \$ 88,590
7	\$ 0 to \$ 83,175	\$ 83,176 to \$ 99,810
* Up to 3 children. Additional children are covered at no additional premium.		
Note: Family size of 1 means coverage for a child who does not live with the parent requesting coverage. Single parent who lives with 1 child counts as a family of two.		
Source: https://info.kp.org/childhealthplan/eligibility.html		

Access for Infants and Mothers (AIM)

Family Size	Monthly Household Income (Gross after AIM Deductions)	Total Cost of AIM Coverage (1.5% of Adjusted Annual Household Income)
2 *	\$ 2,430 to \$ 3,644	\$ 437 to \$ 656
3	\$ 3,053 to \$ 4,579	\$ 549 to \$ 824
4	\$ 3,676 to \$ 5,514	\$ 661 to \$ 992
5	\$ 4,300 to \$ 6,449	\$ 773 to \$ 1,160
6	\$ 4,923 to \$ 7,384	\$ 885 to \$ 1,328
7	\$ 5,546 to \$ 8,319	\$ 997 to \$ 1,496
Each Add'l	Add \$ 625 to \$ 935	Add \$ 112 to \$ 168
* A pregnant woman counts as a family of two.		
Source: http://www.aim.ca.gov/Costs/Income_Guidelines.aspx		

**Women
Infants &
Children (WIC)
Program**

Gross Income Not Over 185% of Federal Poverty Level					
Family Size	Annual	Monthly	2X Weekly	Bi-Weekly	Weekly
1	\$ 20,036	\$ 1,670	\$ 835	\$ 771	\$ 386
2	\$ 26,955	\$ 2,247	\$ 1,124	\$ 1,037	\$ 519
3	\$ 33,874	\$ 2,823	\$ 1,412	\$ 1,303	\$ 652
4	\$ 40,793	\$ 3,400	\$ 1,700	\$ 1,569	\$ 785
5	\$ 47,712	\$ 3,976	\$ 1,988	\$ 1,836	\$ 918
6	\$ 54,631	\$ 4,553	\$ 2,277	\$ 2,102	\$ 1,051
7	\$ 61,550	\$ 5,130	\$ 2,565	\$ 2,368	\$ 1,184
Add'l	Add \$ 6,919	Add \$ 577	Add \$ 289	Add \$ 267	Add \$ 134
Source: http://www.cdph.ca.gov/programs/wicworks/Documents/WIC-IncomeGuidelines-WIC.pdf					

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Mental Health Services



- * Mental Health Services
- * San Francisco Behavioral Health Plan
- * Early and Periodic Screening, Diagnosis and Treatment EPSDT Medi-Cal
- * Healthy Families Mental Health Services
- * Special Education Mental Health
- * Substance Abuse Treatment Services
- * Transition Aged Youth TAY System of Care
- * EPSDT Referrals

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Mental Health Services for Children



Children may need mental health services for a variety of reasons. There are children who are at risk for mental health disorders due to family history or family and community risk factors. In general, treatment services focus on children who have a mental health disorder and are already showing symptoms.

A mental health disorder is a condition that:

- Occurs over a period of time, and
- Markedly affects the child's ability to function in childcare, school, at home and/or in the community

A child with a mental health disorder:

- Has significant difficulty making and keeping interpersonal relationships
- Exhibits inappropriate types of behaviors and feelings
- May have pervasive unhappiness
- May develop physical symptoms or fears that prohibit them from participation in daily activities

A mental health disorder in a young child:

- Can present as difficulties in behavior regulation and attachment

Mental Health Services are available for children through several different programs. Children with mental health disorders may also have coexisting health and/or developmental disabilities. They may be eligible to receive services through more than one program, therefore coordination of care is important.

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San Francisco Behavioral Health Plan



San Francisco Behavioral Health Plan offers a full range of specialty Behavioral health services provided by a culturally diverse network of community Behavioral health programs, clinics and private psychiatrists, psychologists, and therapists. Most people seeking behavioral health services need only basic counseling services. For those who are in need of more extensive treatment, the S.F. Behavioral Health Plan offers an array of services

Population-served Services are available to residents of San Francisco who receive Medi-Cal benefits, San Francisco Health Plan members, and to other San Francisco residents with limited resources. Services are approved and provided based on individual clinical need.

Providers S.F. Behavioral Health Plan providers are located throughout San Francisco and many are accessible to public transportation.

Psychiatric Emergency Services: (415) 206-8125
 Mobile Crisis Team: (415) 355-8300
 Comprehensive Child Crisis: (415) 970-3800
 Westside Community Crisis: (415) 355-0311
 S.F. Suicide Prevention: (415) 781-0500

Referrals for behavioral health care services can be made by calling ACCESS. ACCESS is the 24-hour member helpline that answers questions about locating and receiving behavioral health services. The ACCESS line also reviews Medi-Cal eligibility for mental health services. Referrals can be obtained by clients from this line

Contact Information Suicide Prevention: 415-781-0500

Location
 Administrative Offices at 1380 Howard Street, 5th Fl. (at Tenth St.)
 S.F. Behavioral Health Plan providers are located throughout San Francisco.

24-Hour Access Helpline: (415) 255-3737 or (888) 246-3333
 TDD (888) 484-7200

The 24-Hour Access Helpline is available 24 hours a day, 7 days a week.

Languages
 The 24-Hour Access Helpline is prepared to communicate with callers in any language. Translators are utilized if necessary. Providers are available who speak Cantonese, Spanish, Vietnamese, Tagalog, Russian, and other languages.

Fee
 Services are provided to most individuals who receive Medi-Cal benefits at no fee or with a minimum share of cost. For all others, fees are based on a sliding scale.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - Medi-Cal

EPSDT is an entitlement for children, 0 up to age 21, who are Medi-Cal eligible and is designed to provide comprehensive mental health services that can correct or ameliorate mental health problems. These services often include coordination, case management, and an approach which includes family and other providers in the treatment plan.

Agencies utilizing EPSDT funding are generally able to take direct referrals from primary care providers of children with full-scope Medi-Cal.

Referrals Referrals for EPSDT mental health services can be made through by calling the agency directly.

Contact Information (415) 255-3737 **24hr Access Help line SF County**
 (888) 246-3333
 (888) 484-7200 (TDD)

Healthy Families Program

Healthy Families provides two mental health benefits:

- 1) Basic Mental Health services for children who do not have SED diagnoses
- 2) Drug/Alcohol Treatment services

If the mental health need is related to a CCS-eligible condition, those mental health services should be provided through CCS.

Referrals to Healthy Families mental health services must be made by the child's primary care provider.

Referrals	(888) 246-3333	San Francisco County Behavioral Health Care Services
		24-Hour Hotline
Contact Information	(415) 547-7818	Healthy Families Program
	(415) 575-5700	California Children Services (CCS)

Special Education Mental Health

This program combines educational and other mental health services to students through the school district. This program is available to students who are eligible for special education services under the Individuals with Disabilities Act (IDEA) and have been determined to be in need of mental health related services in order to benefit from their education.

Referrals Referrals for mental health evaluation and determination of eligibility for educationally related mental health services (ERMHS) can be initiated by the student's local school district special education Individualized Education Program (IEP) team.

**Contact
Information**

**(415) 255-3737 San Francisco Behavioral Health Care Services
24-Hour Hotline**

Call your... Child's Local School District's Dept. of Special Education:

**SFUSD Special Education Services
Phone: 415-379-7656
FAX: 415-750-8624**

Call your... Special Education Local Planning Area (SELPA) Office:

**SFUSD Special Education Services
Phone: 415-379-7656
FAX: 415-750-8624**

Substance Abuse Treatment Services

Provides access to a comprehensive array of quality, culturally competent & cost effective Alcohol & other drug prevention treatment outreach & education programs

**Contact
Information**

(800) 750-2727

Drugline - (415) 362-3400

San Francisco's Transitional Age Youth Initiative

San Francisco's Transitional Age Youth Initiative works closely with public and private agencies to create a strong system of support for the more than 7,000 San Francisco youth and young adults, ages 16-24, who are in need of coordinated services so that they can enjoy healthy transition to adulthood. We recognize that many young people experience multiple systems, and yet the systems do not intersect, communicate or support young people comprehensively, for this reason we prioritize our advocacy on the transition needs of the following youth:

Involved in Public Systems
Dropped Out of High School
Homeless
Living with Disability or Special Need
Pregnant or Parenting

**Contact
Information**

(415) 701 - 5702

San Francisco's Transitional Age Youth Initiative

(415) 642-4504

**Intensive outpatient mental health services
SF Department of Health Transitional Age Youth**

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Oral/Dental Health Services



*** Oral Health Programs and Services**

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Oral/Dental Health Services

Oral Health Services are provided through several programs in California—the Office of Oral Health, Child Health and Disability Prevention Program (CHDP); Medi-Cal (the Denti-Cal program); California Children’s Services (CCS); Healthy Families; and Regional Center. These programs can **provide preventive care and treatment of dental conditions**. Additionally there are a few community-based programs offered through dental schools and non-profit organizations.

Oral Health Care Programs and Services

CHDP/Denti-Cal

Children with special needs, who are Medi-Cal or CHDP eligible, may receive dental services from a provider who is participating in the state and federally funded Denti-Cal program. Services include annual preventive dental care by participating dentists for Medi-Cal eligible children (3 years of age and older).

Contact Information (800) 322-6384
(800) 423-0507

Denti-Cal Beneficiary Telephone Service Center
Denti-Cal for providers

Web site **Denti-Cal Providers accepting new patients**
<http://www.denti-cal.ca.gov/proreferral/sanfrancisco.pdf>

California Children Services (CCS)

Dental and orthodontic services are provided if they are related to the treatment of the CCS eligible condition or if the CCS eligible condition would complicate routine dental care. Services include preventive and restorative services and general anesthesia when administered in a CCS-approved facility.

Contact (415) 575-5700 **California Children Services (CCS)**

Children’s Hospital Oakland

Provides treatment for baby teeth, preventive care and treatment under anesthesia for children with special health care needs (CSHCN), uncooperative children or those medically compromised. (Generally 0–12 years of age)

Contact (510) 428-3316 **Children’s Hospital Oakland Dental Clinic**

Healthy Families Dental Plans

Children who are enrolled in Healthy Families may receive dental services from a provider who is participating in one of Healthy Families’ dental plans (Access Dental, Delta or Health Net), DeltaCare USA, Safe Guard Dental, Western Dental

Contact (888) 747-1222

Healthy Families Program

Web site

http://healthyfamilies.ca.gov/Plans_Providers/Compare/San_Francisco.aspx

**Oral Health
Care
Programs
(continued)**

Eastmont Wellness Center General Dentistry for Children

Eastmont offers general dentistry for children and youth up to age 16 and accepts Healthy Families and Medi-Cal dental insurance plans. New uninsured patients must make an appointment with the Patient Business Services Department to determine whether family members are eligible for a payor source. Patients without insurance who are not eligible for a program will be offered payment arrangements at a discounted rate of approximately 50% of total charges. An initial deposit must be paid prior to any non-emergency services provided.

Contact (510) 567-5770
Eastmont Wellness Center

6955 Foothill Blvd , Suite 200
Oakland, CA 94612-2413

Web site
http://www.acmedctr.org/dental_care.cfm

Western Dental Services, Inc.

Provides high quality, always affordable dental and oral health care to thousands of people. We accept DentiCal and private insurance, offer no-interest payment plans, and have individual and group plans to make dental and oral health care convenient and accessible for anyone in California

Contact (415) 552-1200
Western Dental Services, Inc.

1282 Market Street
San Francisco, CA 94102

Web site
<http://www.westerndental.com>

UCSF Center for Orofacial Pain

The University of San Francisco offers a dental clinic and hospital dentistry serving patients with developmental disabilities or who are medically compromised. Medi-Cal, Denti-Cal and various dental and medical insurance coverages may be accepted.

**Contact (415) 476-8298
(415) 502-6489 FX**
UCSF Center for Orofacial Pain

707 Parnassus Ave., Room D1050
San Francisco, CA 94143-0755

(415) 476-5608
UCSF Dental Clinic

100 Buchanan Street
San Francisco, CA 94102

**Dr. Jeffereny Saladin
Dental Corp**
(415) 692-0273
Dr. Jeffereny Saladin

2480 Mission Street SUITE 323
San Francisco, CA 94110

**Oral Health
Care
Programs
(continued)**

Dental Schools

Most Dental Schools do not have separate clinics for children with special needs, but integrate these children into the general pediatric or advanced general dentistry clinics. Services are usually covered through Denti-Cal, third party payers or fee for service (usually reduced fees).

Contact (415) 476-3276

UCSF Pediatric Clinic

707 Parnassus Ave., 1st floor
San Francisco
Accept children up to age 17, any disability

(415) 929-6550

UOP Pediatric Clinic

2155 Webster St.
San Francisco
Accept children (0 up to age 14)

Contact

(510) 489-5200

UOP Union City Dental Care Center

1203 J Street
Union City
Accept children (7 and up)

Public Health Clearinghouse (PHC)

PHC is a service of the San Francisco Public Health Department. It keeps an updated referral database of dentists and physicians who accept Medi-Cal. It also provides information on different options for health coverage, including clinics that offer a sliding fee scale.

(888) 604-4636

Referrals for dentists and dental clinics

Golden Gate Regional Center (GGRC)

Children who are eligible for Regional Center and have no other access to dental care may be able to be funded for care. Also Regional Center may be able to supplement a family's dental care for services such as general anesthesia or orthodontics if the need is related to the developmental disability.

(415) 546-9222

Golden Gate Regional Center

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- * CalWORKS
- * Food Assistance Programs
- * Housing
- * In-Home Supportive Services (IHSS)
- * Supplemental Security Income (SSI) Benefits
- * Transportation

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California Work Opportunity and Responsibility to Kids (CalWORKs) is the name of California's Temporary Aid to Needy Families (TANF) program (formerly AFDC).

CalWORKs:

- * Assures that welfare is a temporary support in times of crisis, rather than a way of life
- * Encourages and rewards personal responsibility and accountability by recipients
- * Fosters a "Work First" attitude by enforcing strict work requirements
- * Gives counties the flexibility they need to meet recipients' needs

Services What services are provided?

- * Cash benefits
- * Referrals to Medi-Cal and Food Stamps

Additional Services Available to non-working participants seeking employment:

- * Vocational education & training
- * Adult basic education and employment

Available to working participants:

- * Child care
- * Transportation
- * Work expenses and counseling

Time Limits What are the time limits for benefits?

Time limits start when the county and recipient sign their new welfare-to-work plan for meeting specified goals.

- * There is a five year time limit for adults
 - * Children can remain on aid if otherwise eligible under the Safety Net program
 - * There are special services for pregnant and parenting teens through the CalLearn program
 - * By July 1, 2011, CalWorks must show that 50% of participants have met the work requirement (compared to 22% currently).
- Those not working will be subject to a regular six month self-sufficiency review.

Work Requirements What are the work requirements for the program?

- * Adults must accept any legal job unless otherwise exempted
- * Recipients will participate in an initial 4-week period of job search
- * Following job search, adults in families receiving assistance will be required to work or be in work activities upon completion of an assessment
- * Recipients needing child care to participate in welfare-to-work activities will receive subsidized childcare

Enrollment	How do you enroll? Contact the county Social Services Agency, Department of Welfare to Work/CalWORKs or local Public Assistance benefit centers.
Contact Information	CA Department of Social Services California Work Opportunity and Responsibility to Kids (CalWORKs)
Web site	http://www.dss.cahwnet.gov/cdssweb/pg54.htm
(415) 558-1001	SF Department of Human Services / CalWORKs
(415) 558-1001 (877) 366-3076	Food Assistance Service Center / Cal Fresh 1235 Mission Street San Francisco, CA 94103



Food Assistance Programs

San Francisco Food Bank

The San Francisco Food Bank is the critical link between food and people. ...
than 45 million pounds of food to meet an ever-growing need in our community.

Contact Information (415) 282-1900 San Francisco Food Bank

Child Nutrition Program

This is a part of the national school breakfast and lunch programs.

- * Special diets can be requested by the primary care provider
- * Schools are required to serve special diet (food, texture) to "children whose handicap restricts their diet" [7CFR 15b 26 (d)] at no additional cost to families

Contact Information Call your... Child's Local School Principal

CalFresh (Food Stamp Program)

CalFresh is the only Federal benefit program that generally is available to all who need it and meet the requisite eligibility standards. In California, the CA Department of Social Services (CDSS) runs the federal Food Stamp Program under the guidance and standards established by Congress and the U.S. Department of Agriculture (USDA).

Contact Information	(415) 558-1001	Food Assistance Service Center/ CalFresh
	(877) 366-3076	1235 Mission Street
		San Francisco, CA 94103

Women, Infants & Children (WIC) Program

Supplemental Nutrition Program

[see WIC Program information in Health Services section of binder]

Contact Information	(888) WIC-WORKS	WIC California toll-free Information Line
	(888) 942-9675	
	(415) 206-4594	SFGH WIC Clinic
	(415) 657-1724	Sliver Avenue Family Health Center WIC Clinic
	(415) 364-7654	Chinatown PH Center WIC Clinic
	(415) 682-1928	Ocean Park Health Center WIC Clinic
	(415) 671-7059	Southeast Health Center WIC Clinic

Web site <http://www.wicworks.ca.gov>

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Housing

Housing information is available at **Helplink 2-1-1, a nonprofit agency based in San Francisco that serves all of San Francisco County.** Helplink maintains a computerized database of housing units in San Francisco County and provides free information on housing-related services for property managers or for persons seeking housing.

Services Helplink 2-1-1 is a service of United Way of the Bay Area

Contact Information	2-1-1	Helplink 2-1-1
	(415) 808 - 4300	Main Number
	(415) 808 - 4444	Spanish
	(415) 808 - 7339	Chinese
	(415) 808 - 4440	TTY
	Web site	http://www.uwba.org

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In-Home Supportive Services (IHSS)

In-Home Supportive Services (IHSS) program is designed to allow low-income people who are aged or have a disability to remain safely in their own homes.

The IHSS program is administered by the county Social Services Agency, Department of Adult and Aging Services.

Services What services are provided?

- * Housecleaning
- * Meal preparation
- * Laundry
- * Grocery shopping
- * Personal care services (including paramedical services)
- * Accompaniment to medical appointments
- * Protective supervision for the mentally impaired.

Eligibility Who is eligible?

- * Recipients must be United States citizens or qualified aliens, and California residents
- * Recipients must live at a home of their choosing (those living in hospitals, long-term care facilities and licensed community care facilities are not eligible)
- * People over 65, people who are blind or disabled who meet specific criteria related to Supplemental Security Income/State Supplemental Program (SSI/SSP) eligibility (including children)
- * Current recipients of SSI/SSP
- * People who meet all the eligibility criteria for SSI/SSP except that income is above SSI/SSP levels (in this case some income may be required to pay share of cost for IHSS benefits)
- * People who meet all the eligibility criteria for SSI/SSP, including income, but do not receive SSI/SSP
- * Medi-Cal recipients who meet SSI/SSP disability criteria
- * Personal property may not exceed \$2000 for an individual or \$3000 for a couple

Additional Services What other services are offered?

- * IHSS recipients are automatically eligible for Medi-Cal for their medical/health care.

Providers How are IHSS organized and delivered?

- * If you are approved by IHSS, you must hire someone (your individual provider) to perform the authorized services. You are considered your provider's employer.
- * You and your provider must complete and submit timesheets to verify services delivered for the month.
- * A parent may be the provider for a child with a severe disability if the parent is prevented from working full-time because of the child's needs and there is no appropriate caregiver available. The money a parent receives to be the IHSS provider may not affect the child's SSI but it may affect the family's welfare payments.
- * Providers may be required to undergo finger-printing and face-to-face provider enrollment procedures under new regulations.

- Application Process How does a person receive IHSS services?
- * To apply for IHSS, complete an application and submit it to the county Social Services Agency, Department of Adult and Aging Services, IHSS office.
 - * A county social worker will interview the applicant at home to determine eligibility and need for IHSS.
 - * If approved, applicants will be notified of the services and the number of hours per month which have been authorized.
 - * For Regional Center clients, the service coordinator can assist with the application process.

Individuals may apply for IHSS over the telephone.

Staff will take application information and forward the information for follow-up, which will include a home call and services assessment.

Contact Information (415) 243-4477 Main office and on call line
 (415) 234-4407 FAX
 (415) 355-6700 Referral & Assistance line

Web site <http://www.dss.cahwnet.gov/cdssweb/PG139.htm>



Supplemental Security Income (SSI) Benefits

Supplemental Security Income (SSI) Benefits is a program run by the Social Security Administration (SSA) that provides monthly income to persons (adults and children) who meet the eligibility criteria.

Eligibility Who is eligible?

The following criteria are for children who may qualify for SSI.
(Other criteria exist for adults, including the elderly.)

Children Who May Qualify for SSI (under age 18, or students 18 up to age 22)		
Requirement	Definition	Exceptions/Exclusions
Blind*	<ul style="list-style-type: none"> Corrected vision of 20/200 or less in better eye Field of vision less than 20 degrees 	Person whose visual impairment is not severe enough to be considered blind may qualify under non-blind disability rules
Disabled*	Physical or mental impairment that results in "marked and severe functional limitations" and must be expected to last at least 12 months or result in death	
Limited income	Below \$500 a month for a child	Not all income counts. Contact the Social Security Administration for details.
Limited resources (things a person owns)	\$2,000 for a child \$4000 parent+child resources in 1-parent family \$5000 parent+child resources in 2-parent family	Not all resources count. Contact the Social Security Administration for details.
Citizenship/Residence	<ul style="list-style-type: none"> Resides in one of the 50 states, Washington DC or the N. Mariana Islands; and U.S. citizen or national; or Certain American Indians; or Lawful permanent resident with 40 work credits; or Certain non-citizens with a military service connection; or Certain refugees or asylum-seeking non-citizens during the first seven years; or Certain non-citizens in the U.S. or receiving SSI on 8/22/1996 	Certain children of U.S. armed forces personnel stationed abroad

* Only one of these criteria must be met, however multiple disabilities may result in increased SSI benefits income.

Additional Services	What other services are offered? Medical Assistance If a recipient receives SSI payments they usually qualify for Fee-for-Service Medi-Cal automatically. A separate Medi-Cal application is not necessary.	
Services not available in California	What services are not available to SSI recipients in California? Food Stamps SSI recipients in California are not eligible for food stamps because the state includes extra money in the amount it adds to the federal SSI payment instead of issuing food stamps.	
Contact Information	(800) 772-1213 (800)325-0778 TTY	Social Security Administration (7:00am - 7:00pm)
	Web site	http://www.ssa.gov



Transportation

Transportation is a problem for many families; it can impact their ability to get their children to school, medical appointments and around the community for daily activities and recreation. **There are a number of programs providing transportation services to families with children who have special health care needs.** Most cities operate their own specialized transportation programs and there are some programs that are countywide. All programs have different geographic and eligibility requirements.

Golden Gate Regional Center (GGRC) and **California Children Services (CCS)** can assist their clients in obtaining appropriate transportation services.

Programs and Services	School Transportation	
	Children with special needs who are receiving special education services may be eligible for free transportation. Depending on medical need and other individual criteria, this can include transportation to:	
	<ul style="list-style-type: none"> * Any school the child attends (whether it is in the child's neighborhood or not) * Transportation for off-campus therapies * Transportation to after-school programs 	
	In some cases, parents who can drive their children can receive mileage reimbursement if their child would otherwise qualify for transportation services. In order for a child to receive transportation services, these services must be written into his/her Individualized Education Program (IEP).	
Contact Information	Call your...	Child's Local School District's Dept. of Special Education
	Call your... (415) 379-7697	Special Education Local Planning Area (SELPA) Office: SFUSD 750 25th Avenue, 2nd Floor San Francisco, CA 94121

Medical Care Transportation

Some hospitals or related organizations offer transportation for medical appointments. All of the programs have different geographic and eligibility requirements and may require up to a week's notice, so it is important for families to have this information in advance. Some medical facilities also offer taxi vouchers and/or reduced parking fees. Transportation services are also provided by certain agencies such as the American Cancer Society. Transportation is provided for medical appointments related to that agency's mission and is usually by van or volunteers. California Children Services (CCS) may meet some transportation needs for CCS-eligible children.

Contact Information	Call your...	Medical Facility/Hospital
	Call your... (415) 575-5700 (415) 575-5790 FAX CCS Web site	Medical/Health Agencies California Children Services (CCS) http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

Transportation Programs and Services (continued)

Public Transportation

Many areas in San Francisco County are served by public transportation and also provide specialized transportation services. Many people with disabilities can qualify for reduced fares on public transportation even if they don't qualify for specialized transportation services. Depending on their disability, children with special health care needs may qualify for a reduced fare pass; however, their other family members will travel at full fare. Most buses are equipped with wheelchair lifts and can also accommodate other equipment or service animals.

Fixed Route Transportation

The most inexpensive and flexible option is fixed route transportation. Bay Area Rapid Transit (BART), the public bus systems in San Francisco (Muni) are 100% equipped with lifts for wheelchair users and others who need assistance boarding the bus.

SF Access Program

The SF Access program provides door-to-door shared-ride van services for people in wheelchairs. The SF Access program provides these same services for persons who are ambulatory. These services are available to persons who are unable, because of their disability, to use Muni's accessible bus, train, and streetcars some or all of the time.

Mobility Plus Transportation

Mobility Plus Transportation is a premier provider of transportation services, proudly serving clients throughout California with safe, efficient passenger transportation. Services : Paratransit management and operations, Regional Center transportation, Fixed Route and Shuttle transportation, Corporate shuttles and School transportation

Contact Information	(415) 989-2278	BART San Francisco
	(415) 351-7000	San FranciscoMuni
	(415) 285-6945	SF Access – Paratransit Service
	(415) 351-7090	Paratransit taxi
	(415) 285-6945	Mobility Plus Transportation - Lift Van Reservations & "Where's My Ride?"
	(415) 575-5700	California Children Services, clients only
	(415) 546-9222	Golden Gate Regional Center (GGRC), clients only

511 is your one-stop phone and web source for up-to-the-minute transportation information. It's FREE and available whenever you need it – 24/7 – from anywhere in the nine-county Bay Area.

IN AN EMERGENCY...If you are experiencing a life-threatening emergency, always dial 9-1-1. San Francisco

San Francisco
Para transit
Frequently
Asked
Questions

San Francisco Paratransit Useful Information	
What is San Francisco Paratransit?	San Francisco Paratransit is a van and taxi program for people unable to independently use public transit because of a disability or disabling health condition. Since 1990, the Americans with Disabilities Act (ADA) has required all public transit agencies to provide paratransit services to qualified disabled people.
Where is service available?	Service is available in the same area where SF Muni operates. Service is available to and from points in San Francisco. Riders can also arrange to transfer to paratransit services in other parts of the Bay Area.
At what times is service available?	Service is available during the hours when Muni transit or BART trains are running in each particular area. SFP's reservations staff can tell you if service is available when and where you want it.
How is service provided?	A central office takes ride requests and schedules the trips. Contracted paratransit operators carry passengers in vehicles marked with the MV logo. You will share the vehicle with other paratransit riders.
How can I receive the service?	<p>All riders must be certified as eligible to use the program. People who are unable to use buses or BART due to a disability or disabling health condition are eligible to use SFP service. A few examples of such disabilities would be: memory problems which prevent a person from remembering which bus line to take; the inability to control a wheelchair well enough to board a bus or BART train; or a severe mobility problem which prevents a person from walking to the nearest bus stop.</p> <p>To receive an application to apply for ADA eligibility, or for more information, call SFP Certification Department at the number at the end of this information. Certification must be renewed every three years.</p>
Once I am certified, how can I make a trip?	You must make a reservation to schedule your ride. SFP takes reservations one to seven days in advance. The reservation center is open for calls between 9:00 am to 4:45 p.m., Monday- Friday. If you wait until the day before your trip to make a reservation, you must call before 5:00 p.m. If you want to go to the same place at the same time on a regularly scheduled basis, such as daily, weekly, or several days per week, you can also arrange subscription (repeat) reservations.
What information do I need for making a reservation?	<p>To make a reservation, you will be asked for this information for both the pick-up and drop-off locations:</p> <ul style="list-style-type: none"> • Street address, City, Zip Code • Phone numbers • Desired pick-up time • Appointment time
What do I do on the day of my trip?	<p>When you reserve a ride, you will be given a 20-minute "window" in which to expect your ride. The paratransit vehicle will come to your pick-up address. You must be ready to board the vehicle at the beginning of your 20 minute window. If the driver cannot locate you within 5 minutes of arriving, he or she may leave without you, in order to pick up other riders.</p> <p>If your ride is late, you may call customer services at SFP to find out the estimated time of arrival.</p>

San Francisco
Paratransit
Frequently
Asked
Questions
(continued)

San Francisco Useful Information (continued)	
What assistance can the driver give?	The driver can provide some limited assistance, such as knocking or ringing to let you know of their arrival, or offering a steadying arm to escort you to the vehicle. Drivers must stay within sight of their vehicle, so they may not escort you past the ground floor lobby of any building, or seek you out in an inside office, apartment, or waiting room. Drivers are never permitted to enter residences. The driver will assist you with small packages, for example, up to two standard-sized grocery bags. The driver can move a person in a wheelchair no more than 2 exterior stairs unless in stair assist program.
What if my plans change and I need to cancel my ride?	You may cancel your ride without penalty up to two hours before your pick-up time. If you do not cancel your ride or cancel in less than two hours, you may be considered a "no show." If you no show three times in three months, your service may be suspended
How much do I pay for my trip?	SF Access service costs a certified rider \$2.00 per oneway trip. Cash fares must be paid with exact change. Single ride tickets may be purchased from the San Francisco Paratransit office in any quantity for \$2.00 each. These ride tickets do not expire. SF Access who use a wheelchair wish to take advantage of a free Muni Fast Pass good for unlimited rides on the Muni bus and/or Metro system, a rider must purchase at least \$10 worth of Ride coupons that month from the San Francisco Paratransit office.
What if I have a problem with my ride?	Customer service staff are available on the telephone during all hours that San Francisco Paratransit operates. They can help you with things like an estimated arrival time for a ride which is running late. If you want to register a commendation or a complaint, you can leave a telephone message with the details, and you will receive a written response later.
What other information is available?	Materials, such as the application form, the Riders' Guide and newsletters are available in alternative accessible formats. These include large print, Braille, audio tape and computer diskette.
Are there other paratransit services?	Yes. All the transit agencies in the Bay Area (MUNI, CCCTA, WestCAT, Union City Transit, etc.) offer paratransit services for people with disabilities in their areas. In addition, some cities, counties, or social service agencies offer separate paratransit services. Status as a senior, without specific disabilities, may qualify a person for paratransit services from some cities or agencies.

Contact Information

(415) 351-7000
(415) 285-6495
(415) 351-6945
(415) 351-7050
(415) 351-7052
(415) 351-3942

Web site

San Francisco Paratransit General Information
Where's My Ride?
Reservations
Application
Customer Service - Comments or Complaints
Device for those who are hearing impaired

<http://www.sfparatransit.com>

Family Support & Advocacy



- Q Introduction to Family Support & Advocacy Programs
- Q San Francisco Health Plan
- Q Area Board V
- Q CA Dept. of Insurance (CDI) Consumer Communication Bureau
- Q CA Dept. of Managed Health Care HMO Help Center
- Q Independent Living Resource Center (ILRC)
- Q Child Protective Services (CPS)
- Q Community Alliance for Special Education (CASE)
- Q Disability Rights California (DRC) (formerly Protection & Advocacy - PAI)
- Q Disability Rights Education and Defense Fund (DREDF)
- Q First 5 San Francisco
- Q TALKLine Family Support Center
- Q Support for Families of Children with Disabilities
- Q Family Resource Network of California
- Q Futures Without Violence
- Q Health Consumer Alliance (HCA)
- Q Office of the Patient Advocate
- Q Office of Clients' Rights Advocates (OCRA)
- Q Procedural Safeguards and Referral Services (PSRS)
- Q Respite Care

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Family Support and Advocacy



Families of children and youth with special health care needs are often faced with an array of systems from which they receive services. All of these systems operate under different regulations, have different eligibility requirements and are navigated in different ways. However, all of them require that parents are able to successfully advocate on behalf of their child.

Introduction to Family Support and Advocacy Programs The laws guaranteeing the rights of individuals with special health care needs and their families do not always translate into comprehensive services. Therefore, parents who are more skilled in advocating for their children and themselves are more likely to obtain the services that are appropriate to their child's needs.

There are many programs that provide family support and advocacy services for families of children with special health care needs and the professionals who work with them. Programs cover myriad and often overlapping areas in which families may need support, such as: access to health care and healthful practices; understanding or obtaining benefits; financial planning; legal rights, advice or representation; systems navigation; referrals; protection from violence; housing and transportation; educational planning and support, access to recreational opportunities; strengthening ties to the community, and peer-to-peer support for families, children, and youth transitioning into adulthood.

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San Francisco Area Health Plan



Services

S **San Francisco Health Plan (SFHP)** is a licensed community health plan that provides affordable health care coverage to over 70,000 low and moderate-income families. Members have access to a full spectrum of medical services including preventive care, specialty care, hospitalization, prescription drugs, and family planning services. SFHP was designed by and for the residents it serves, and takes great pride in its ability to accommodate a diverse population that includes young adults, seniors, and people with disabilities.

We were created by the City and County of San Francisco with one purpose: to provide high quality medical care to the largest number of low-income San Francisco residents possible, while supporting San Francisco's public and community-minded doctors, clinics, and hospitals.

Our members choose from over 2,300 primary care providers and specialists, six hospitals, and 200 pharmacies - all in neighborhoods close to where they live. Here are some of the classes available to Alliance members:

How it Works

San Francisco Health Plan is a managed care plan that provides medical, dental, and vision insurance through its programs. The benefits and eligibility requirements for our programs are different depending on which program you or your family qualify for.

In managed care, your doctor (sometimes called a primary care provider or PCP), clinic, hospital, and specialist work together to care for you and your family.

Your doctor provides basic health care needs as part of a medical group. A medical group is made up of specialists and other providers of health care services. A hospital is also connected with the medical group.

Your doctor and medical group direct the care for all of your medical needs. This includes authorizations to see specialists, or to get medical services such as lab tests, x-rays, and hospital care.

Contact (415) 547-7818
Information (415) 547-7826 FAX

San Francisco Health Plan
201 Third Street, 7th Floor
San Francisco, CA 94103

(415) 777-9992
(888) 558-5858
(800) 288-5555

Enrollment
Appointments ARE REQUIRED.
Customer Service

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Area Board V



Area Boards have the responsibility to plan, coordinate, and develop services for persons with developmental disabilities. The Area Boards program is one of several unique programs for people with developmental disabilities mandated under the *Lanterman Developmental Disabilities Services Act*.

Services Area Boards also advocate and protect the rights of people with developmental disabilities and monitor the practices of publicly funded agencies for compliance with local, state and federal laws and pursuing remedies for any violation of such laws.

Area Boards are a source of information and aid for families who receive services through the Regional Centers. Area Boards help families and communities learn about their rights, connect them to needed services, and help people become full members of their communities. There are 13 Area Boards in California. Area Board V serves Alameda, Contra Costa, Marin, San Francisco, and San Mateo counties.

Contact	(510) 286-0439	Area Board V
Information	(510) 286-4397 FAX	1515 Clay Street, Suite 300
		Oakland, CA 94612
	email	ab5@scdd.ca.gov
	(866) 802-0514	State Council on Developmental Disabilities
	(916) 322-8481	1507 21st Street, Suite 210
	(916) 443-4957 FAX	Sacramento, CA 95814
	Email	council@scdd.ca.gov
	Web site	http://www.scdd.ca.gov

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California Department of Insurance (CDI) Consumer Communication Bureau



California Department of Insurance (CDI) is responsible for regulating insurance activity that occurs in California. CDI supervises and provides assistance in the area of health insurance, except for pre-paid or managed care plans. The Consumer Communication Bureau offers assistance to families through the Consumer Hotline.

- Services The Consumer Hotline offers the following services:
- Responding to requests for general information
 - Receiving, investigating, and resolving individual consumer complaints against insurance companies, agents, and brokers that involve violations of statute, regulations, or contractual provisions
 - Initiating legislative and regulatory reforms in areas impacting consumers
 - Tracking trends in code violations and cooperating with enforcement to bring deterrent compliance actions

Contact Information (800) 927-HELP Consumer Hotline
(800) 927-4357
(213) 897-8921
(800) 482-4833 TDD
Web site - <http://www.insurance.ca.gov/0100-consumers>

California Department of Managed Health Care HMO Help Center

Services **H**MO Help Center helps to resolve disputes between families and their health maintenance organizations (HMOs). This service covers all managed care health plans including Medi-Cal managed care and private health plans. The HMO Help Center provides information about consumer rights and serves as the intake office for the managed care complaint process.

Contact Information (888) HMO-2219 HMO Help Center
(888) 466-2219
(916) 324-8176
(916) 255-5241 FX
(877) 688-9891 TDD
Web site <http://www.hmohelp.ca.gov>

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Independent Living Resource Center (ILRC)



Independent Living Resource Center (ILRC) is a disability rights advocacy and support organization. Our mission is to ensure that people with disabilities are full social and economic partners, within their families and within a fully accessible community.

Services

ILRC Services	
Health Care Access	Healthcare Access services focuses primarily on the rights of consumers who are members of Health Maintenance Organizations (HMOs) such as Kaiser Permanente, Health Net, Blue Cross, Blue Shield, San Francisco Health Plan and Chinese Community Health Plan.
Transition and Diversion	Transition and Diversion Services offers support to individuals currently residing in long-term care institutions or rehabilitation facilities; those facing potential institutionalization; as well as, those who desire to return to or maintain independent community living.
Assistive Technology	ILRCSF services include assistance with the identification of AT options; advocacy for those needing insurance companies to cover necessary equipment; and, information or referral of professional AT assessment services and/or vendors. Periodic workshops are held for individuals with a disability and those transitioning from institutional settings to introduce and illustrate the importance of AT in successful independent living.
Deaf Services	ILRCSF provides services for the Deaf and Hearing Impaired Persons while simultaneously advocating for communications access for these individuals. Assistance and support are available to individuals who wish to access a variety of agency services, including housing counseling and applying for emergency housing funds
Information & Referral	Information and Referral maintains hundreds of listings for a myriad of community resources. Individuals with disabilities, family members, and others can contact us to find out where to go for particular services, how to work with public agencies, where to find Assistive Technology (AT), what to do if disability related discrimination occurs, etc.
Benefits	Benefits services, such as counseling, education and referral are provided to consumers that address issues of public cash assistance, private and public health insurance and work incentive programs.
Housing	Housing Counseling and Advocacy provides individual housing information and guidance with a focus upon tenants' rights, fair housing, and advocacy, in addition to assisting consumers in the application for emergency rental assistance funds. Available to consumers are several ILRCSF produced publications relative to housing and disabilities. Tenants and housing providers are invited to attend the fair housing training workshops, provide low-income housing information for distribution to other ILRCSF partners or participate in one of the monthly housing skills search sessions.

Services
(continued)

ILRC Services (continued)	
Peer Support Services	Counseling and peer support is provided to assist individuals, couples, families and groups with disability related issues. A weekly support group offers a safe, supportive environment for people with all types of disabilities to meet and discuss various aspects of disabilities as it affects their daily lives. Support group membership requires an interview process.
Latino Community Services	Through its Latino Outreach Project, ILRCSF provides bilingual, bicultural services to (primarily) Spanish speaking consumers with disabilities while simultaneously advocating for full language access. Focusing on San Francisco's Mission District, staff works collaboratively with the numerous organizations already working in the area, to encourage residents to utilize community programs.
Advocacy	Through Systems Change Advocacy, ILRCSF works to educate consumers, the general public, and those in decision- making positions, about issues critical to the well being of the disability community.
Peer Support Services	Counseling and peer support is provided to assist individuals, couples, families and groups with disability related issues. A weekly support group offers a safe, supportive environment for people with all types of disabilities to meet and discuss various aspects of disabilities as it affects their daily lives. Support group membership requires an interview process.
Chinese Community Services	Through its Chinatown Outreach Project, ILRCSF provides bilingual, bicultural services for Chinese speaking consumers with disabilities while simultaneously advocating for full language access. Although staff is available to assist individuals to access a variety of agency services, the program focuses on financial and medical benefits, HMO rights, In Home Support Services (IHSS), and the dissemination of materials written in Chinese.

How do you enroll?

Referrals for services can be made by anyone: consumer, family member and professional. Call CIL for an appointment. Individuals (age 14 and older) with all types of disabilities are eligible for CIL services. However, CIL may receive grants that allow them to serve younger children as well.

Contact
Information

ILRC
649 Mission Street, 3rd Floor,
San Francisco, CA 94105-4128

(415) 543-6222
(415) 543-6318 FAX
(415)543-6698 TTY

Email: info@ilrcsf.org
website: www.ilrcsf.org



Child Protective Services (CPS)

Source: Legal Services for Children, Inc., based on CA law as of 06/01/01

Child Protective Services (CPS) is an agency that investigates and protects children from physical abuse, emotional abuse, sexual abuse, verbal abuse and neglect.

Reporting Abuse/ Intake Procedures Anyone can call CPS to report suspected child abuse or neglect (physical, emotional, sexual and neglect). The intake worker on the phone will ask many questions and determine the danger of the situation. If a child is in immediate danger, CPS will send a social worker to the home to investigate and potentially remove the children from a dangerous situation within 24 hours. If the case does not appear to be immediately dangerous, a social worker will visit the family within 10 days of the call. If the intake worker does not think that the call is serious, the case will be closed; however, a record of the call will be kept on file.

Short Term Action After meeting with a child, if CPS is concerned about the child's safety, they have several choices. Short term:

- They might take the child to a friend's or relative's home.
- They might take the child to a temporary foster care placement with a family or in a group home while they investigate the child abuse charges. If the social worker and the court believe that a child is not safe in the home, the child's long term options will be discussed.

Long Term Involvement Long term involvement with CPS (*an open CPS case*) means that the child is a dependent of the court. That is, the court is the child's legal guardian. The child is now in the *dependency system*, also known as the foster care system. The child's social worker will work with the family through family reunification services to attempt to make the parent's home safe and comfortable for the child to live in again. If family reunification is not possible, a child may remain in the foster care system until he or she turns 18, unless a relative or friend becomes the child's legal guardian or adopts the child.

Record Keeping All CPS calls are kept on record. Even if a CPS worker does not open a case or if they close a case after a brief investigation, they keep a record of reports. Therefore, if one demonstrates a long history of abuse or neglect, it will be easier to convince CPS that a child is not safe in the home.

Contact Information

911	Police Emergency (if in immediate danger)
(800) 856-5553	HSA of SF Family Children Services (Child Welfare)
	Under 18 and being physically, sexually or emotionally abused
(800) 422-4453	National Child Abuse Hotline (for CPS number in your area)
(415) 441-KIDS	24-Hour Crisis Line:
	Children/youth who might hurt themselves or someone else
(800) 843-5200	California Youth Crisis Line – Runaway Hotline
	San Francisco Emergency or "Runaway" Shelters:
(888) 811-SAFE	Connecting Point
(415) 292-5228	Hamilton Family Emergency Center

Legal Services for Children, Inc. <http://www.lsc-sf.org>

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Community Alliance for Special Education (CASE)



Community Alliance for Special Education (CASE) provides legal support, representation and educational consulting to parents whose children need appropriate special education services. CASE advocacy staff are trained in special education law and provide services throughout the San Francisco Bay Area. They help families and school districts work together when designing appropriate Individualized Education Programs (IEPs) for eligible students with disabilities so that they can succeed in school, find a job, and become productive members of their community.

Services What services are provided?

- Technical assistance consultations to families and professionals on special education rights, responsibilities and services regarding specific special education students or issues.
- Direct representation at Individual Education Program (IEP) meetings, due process mediations, and administrative hearings if necessary on behalf of students with disabilities and their parents.
- Training on special education rights and services to parents so they can better advocate for appropriate special education programs and services on behalf of children with disabilities.

Fees Representation fees are based on a family income sliding scale.

Appointment Call CASE to set up a future phone appointment with a CASE attorney or advocate.

Contact	(415) 431-2285	Community Alliance for Special Education (CASE)
Information	(415) 431-2289 FAX	1550 Bryant Street, Suite 738
		San Francisco, CA 94103
	email	info@caseadvocacy.org
	Web site	http://www.caseadvocacy.org
	(510) 783-5333	CASE - East Bay
		680 West Tennyson Road
		Hayward, CA 94544

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Disability Rights California (DRC) (formerly Protection & Advocacy - PAI)



Disability Rights CA (DRC), is a nonprofit agency that works in partnership with people with disabilities—to protect, advocate for and advance their human, legal and service rights.

- Eligibility** A federally mandated program, DRC serves people in California who:
- q Have a developmental disability
 - q Are Regional Center clients
 - q Have significant psychiatric disabilities or emotional impairments; **and** are currently in a facility that provides care or treatment; **or** it has been 90 days or less since discharge from such a facility
 - q Are patients in a state psychiatric hospital
 - q Have a disability as defined in the Americans with Disabilities Act (ADA), and are not eligible under other protection and advocacy programs
 - q Need access to new technologies to help live a fuller, more independent life

- Services** DRC offers some direct representation, but also serves as an information and referral source. DRC staff refer families to low cost and free legal representation. DRC publishes an array of books and fact sheets in several languages that provide information on rights and strategies for obtaining appropriate services in the areas of:
- q Americans with Disabilities Act (ADA)
 - q Advocacy
 - q Assistive Technology
 - q Government Benefits
 - q Health Benefits
 - q Housing
 - q Immigration
 - q In-Home Supportive Services (IHSS)
 - q Information on Protection & Advocacy, Inc. (PAI)
 - q Lanterman Act (Regional Center Services)
 - q Medi-Cal/Medicare/Medicaid
 - q Mental Health
 - q Newsletters
 - q Investigation Reports
 - q Social Security (SSI/SSDI/SSP)
 - q Special Education
 - q Transportation

Contact Information (510) 267-1200 Disability Rights California (DRC)
(800) 776-5746 1330 Broadway, Suite 500
(800) 719-5798 TDD Oakland, CA 94612

(916) 575-2165 Office of Patients' Rights
(800) 390-7032 Office of Clients' Rights Advocacy (OCRA)
[see OCRA information in this section]

Web site <http://www.disabilityrightscalifornia.org>

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Disability Rights Education & Defense Fund (DREDF) - Children & Family Advocacy Program



Disability Rights Education and Defense Fund (DREDF) is a national nonprofit law and policy center whose mission is to advance the civil and human rights of people with disabilities through legal advocacy, training, education and public policy. DREDF envisions a just world where all people, with and without disabilities, live full and independent lives free of discrimination. Free and appropriate public education (FAPE) of children with disabilities in the least restrictive environment (LRE), legal guarantees of the Individuals with Disabilities Education Act (IDEA), provide a critical foundation for integration and independent living in adulthood. Through its Children & Family Advocacy Program, DREDF works to make sure that rights are preserved and that the interests of children with disabilities and their families are represented in the educational reform debate.

Objectives DREDF objectives are:

- ◻ To help parents of children with disabilities secure the educational and related services that state and federal laws guarantee to their children.
- ◻ To monitor implementation of and compliance with the laws and to shape education public policy.
- ◻ To extend and expand the concept of integration mandated under IDEA and to halt the abuse of children with severe disabilities in public schools.

Foster Youth Resources for Education (FYRE) DREDF also runs a first-of-its-kind program, Foster Youth Resources for Education (FYRE) to ensure that foster youth with disabilities and out-of-home youth with disabilities, have comprehensive education supports. Although almost 40% of foster children and youth qualify for special education, they often lack effective educational advocacy and support. FYRE can provide direct support and training to foster parents and kin caregivers, older foster youth, child welfare workers, and dependency personnel within Alameda County. Free services.

Foster Youth with Disabilities in Transition (FYDT) With support from the CA Department of Rehabilitation, DREDF offers an online Clearinghouse and training in CA to support foster youth with disabilities and out-of-home youth with disabilities transitioning to adult life, post-secondary education, and employment. Selected resources help foster parents, kin care providers, child welfare workers, educators, Court Appointed Special Advocates (CASAs) and other professionals to provide effective services and supports for children with disabilities in foster care. Free services.

Services	DREDF Children & Family Advocacy Program Services	
Parent Training		DREDF annually trains 1,200 parents of disabled children to enable them to advocate effectively for their children.
Networking		DREDF facilitates mutual support networks among parents who can help each other with similar problems.
Technical Assistance/ Information and Referral		DREDF responds to 200 inquiries each month concerning laws and regulations, organizing coalitions and building effective networks, and developing strategies for working with schools and other community agencies. DREDF develops and distributes special education guides and training materials.
Educational Advocacy		DREDF assists families of the nearly 46,000 children in special education in Alameda, Contra Costa and Yolo counties in solving educational problems at the least adversarial level. DREDF also serves children with disabilities who do not qualify for special education under IDEA, but who qualify under Section 504 of the Rehabilitation Act and trains professionals who serve children.
Litigation		DREDF handles high-impact cases affecting the most important educational rights of children with disabilities.
Public Policy		In coalitions on a local, state and national level, DREDF monitors implementation of and compliance with the laws and works to shape national education policy reform.

Contact Information	(510) 644-2555	V/TTY	Disability Rights Education & Defense Fund (DREDF)
	(800) 348-4232		Ed Roberts Campus
	(510) 841-8645	FAX	Berkeley, CA 94703
	email	info@dredf.org	
	DREDF Web site	http://www.dredf.org	

Family Advocacy http://www.dredf.org/programs/family_advocacy.shtml

PTI <http://www.dredf.org/programs/PTI.shtml>

FYRE <http://www.dredf.org/programs/foster.shtml>

FYDT <http://www.dredf.org/programs/clearinghouse>

Special Ed Resources http://www.dredf.org/special_education/special_ed_resources.shtml

Training Materials http://www.dredf.org/special_education/trainings.shtml

First 5 San Francisco



First 5 San Francisco provides access to resources and support on an as-needed basis. Our best practice model of service delivery is relationship-based, family-centered and builds on family strengths. F5SF strongly believes that providers need to partner with families on behalf of the children. F5SF is weaving together a coalition of providers that will offer a menu of social support that is linked and integrated in order to maximize and strengthen children's lives at home, in child care and in the community.

Services

Intensive Family Support Programs	
Improved Child Health	Children can't do their best if they don't feel their best. That's why we will continue to make sure that children have access to quality health care, beginning before they are born. We will also expand access to include comprehensive dental, vision, hearing, and developmental screenings.
Enhanced Child Development	Adults play a crucial part in a child's development, which is why we will focus on enhancing the relationships between children, their families and their early childhood teachers and childcare providers. We will also work on strengthening the abilities of key caregivers.
Improved Family Functioning	Raising children is an enormous responsibility. All families can benefit from support and guidance in a child's development, which is why we have created a strong, neighborhood-based network of family resource centers (FRCs) that meet those needs. We will focus on building these FRCs as a platform for supporting families and their young children.
Improved Systems of Care	We are constantly working to help child-devoted organizations create more accessible, effective programs. We partner with parents, other city agencies and foundations to recommend improvements in public systems of care for young children.

(415) 934-4849 First 5 San Francisco
 (415) 565-0494 1390 Market Street, Suite 318
 San Francisco, CA 94102

Web site <http://www.first5sf.org>

email admin@first5sf.org

Family Resource Network of California

Family Resource Centers Network of California (FRCNCA) is a coalition of California's 47 Family Resource Centers. The 47 Early Start Family Resource Centers are funded through the Individual with Disabilities Education Act (IDEA) — Infants and Toddlers Part C. Members are represented on the statewide network through Regional Representatives.

What are Family Resource Centers?

In California, Early Start Family Resource Centers are part of the Early Start Program. Staffed by families of children with special needs, family resource centers offer parent-to-parent support and help parents, families, and children locate and use needed services. They offer support services and resources in many languages, which may include newsletters, resource libraries, websites, parent-to-parent groups, sibling support groups, warmlines, and information and referral for parents and professionals

Your local ESFRC will be able to provide you with:

- Parent to parent support services
- Training and conferences
- Resources and information
- Referral services
- Assistance at transition at age three

Find your local ESFRC : <http://www.frcnca.org/frcnca-directory/>

Contact Information:

Family Resource Network of California (FRCNCA)
PO Box 5195
Fair Oaks, CA 95628
Phone: 916/962-0832
Fax: 916/962-0493
info@frcnca.org
<http://www.frcnca.org>

TALK Line Family Support Center



TALK Line Family Support Center is an essential part of the San Francisco Child Abuse Prevention Center.

Services

TALK Line Family Support Center Services	
Family Support Center	Our Family Support Center is a supportive, homelike setting where parents and caregivers can come to find resources and referrals, receive counseling, meet and share feelings and concerns with other parents, attend a support or parenting skills group, use the free phone, computer and printer, or just relax, enjoy free refreshments and spend some time apart from their children.
TALK LINE 415-444-KIDS	The TALK Line operates round-the-clock (24 hours a day, 7 days a week, 365 days a year) and has provided service virtually uninterrupted for more than 30 years. Enhanced translation capacity allows the TALK Line to handle critical calls in more than 170 languages. The TALK Line is free of charge for all callers.
Counseling and Therapy Services	The Center's counseling program provides families the opportunity to work with a therapist in either a short-term or open-ended time frame to address emotional and behavioral difficulties that may interfere with effective parenting and contribute to ongoing family discord and stress.
Children's Playroom	The Children's Playroom provides a warm, supportive, and respectful environment, where parents are assisted to create and experience shared positive emotions with each of their children, and children are supported to improve peer relationships, regulate emotional outbursts, and express their needs and emotions appropriately.
Respite Care	Since 1977, the Respite Care program has provided free, emergency child care to parents who need time to handle crises, attend appointments, find a job, look for housing and attend to other essential needs.
SafeStart	SafeStart is available to any family residing in San Francisco with a child aged six or under who may have been exposed to domestic or community violence. All services are optional, free, confidential and available in English, Spanish, Cantonese and other Asian languages
Community Education	Through the San Francisco Child Abuse Prevention Center, our Child Safety Awareness Program provides education and training to schools, PTAs, civic organizations, clubs and professional groups about the prevention of child abuse and neglect, both inside and outside of the home.

Contact Information

(415)441-KIDS (5437)
talkline@sfcapc.org

www.talklineforparents.org

TALK Line Family Support Center
1757 Waller Street
San Francisco, CA 94117

Support for Families of Children with Disabilities

Support for Families of Children With Disabilities is a parent-run San Francisco-based nonprofit organization founded in 1982. We support families of children with any kind of disability or special health care need as they face challenges.

Support for Families Services	
Phone Line/ Drop-In Center/ Resource Libraries	Support for Families staff (parents themselves) can provide individualized information, referrals, and help. Phone Line Staff speak Chinese, English, Spanish. More than 3,000 books, videotapes, DVD's and toys are available to families and professionals.
Support Groups	Support groups help families find solutions to challenges, learn advocacy skills, explore resources, and gain strength by sharing experiences with peers.
Counseling and Therapy Services	The Center's counseling program provides families the opportunity to work with a therapist in either a short-term or open-ended time frame to address emotional and behavioral difficulties that may interfere with effective parenting and contribute to ongoing family discord and stress.
Volunteer Parent Mentors	Trained volunteer Parent Mentors can be matched with a family based on a shared culture, language, or disability issue.
Educational Workshops and Clinics	Based on needs expressed by families, monthly parent/professional workshops and weekly small-group clinics help parents and professionals learn about resources, rights and responsibilities.
Family Links to Mental Health	Peer parents and mental health clinicians provide peer support, professional consultation, and help for families and professionals in accessing mental health and other services for children.
Community Outreach	Staff and volunteers make presentations and conduct training on disability issues and parent perspectives to university classes, community agencies, and professional groups.
Family Gatherings	Quarterly events, such as an annual ice-skating party and Halloween party give families a chance to socialize and network in a fun, relaxed atmosphere.
Newsletter	A quarterly Newsletter in English, Spanish, and Chinese offers articles of interest to families, professionals, and the community.

Contact Information

(415) 282-7494 Support for Families
 (415) 282-1226 FAX 1663 Mission Street, 7th Floor
 San Francisco, CA 94103
 (415) 920-5040 Support for Families Warmline:

email info@supportforfamilies.org

Futures Without Violence



Futures Without Violence Everyone has the right to live free of violence. Futures Without Violence, formerly Family Violence Prevention Fund, works to prevent and end violence against women and children around the world

Services

- Women & Girls: Advancing the health and wellbeing of women and girls to build stronger communities.
- Men & Boys: Men as role models are part of the solution.
- Child Wellbeing: Because the youngest victims often go unseen and unheard.
- Tweens & Teens: Helping young people develop healthy relationships.
- Health: Improving the health care response to domestic violence.
- Judges: Aiding judges to make constructive decisions in support of women and children facing violence.
- Employers & Employees: Creating a safe workplace and enacting policies that help prevent violence.
- Leadership Training Programs: Building community leadership to grow skills and foster sustainability.
- Policy & Advocacy: Transforming international and domestic policy to improve lives around the world.
- Global Prevention: Creating futures without violence worldwide.

Services are available in English and Spanish.

Sliding scale for fees. No one turned away for lack of funds.

Contact Information

(415) 678-5500	Futures Without Violence
(415) 529-2930 FAX	100 Montgomery Street, The Presidio
(800) 595-4889 TTY	San Francisco, CA 94129

e-mail: info@futureswithoutviolence.org

website: www.futureswithoutviolence.org

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Health Consumer Alliance (HCA)



H **Health Consumer Alliance (HCA) is a partnership of consumer assistance programs operated by community-based legal services organizations with the common mission of helping low income people obtain essential health care.**

Services Consumer assistance programs that make up the HCA provide assistance in resolving specific problems with Medi-Cal or Healthy Families, including eligibility. The HCA helps consumers establish or maintain health coverage. It ensures that low-income consumers with health coverage have adequate access to essential services, including the services provided through managed care plans.

The HCA also provides information through a newsletter and website. Consumer education materials in 13 languages are available.

Health Consumer Centers currently operate in 13 California counties — Alameda, El Dorado, Fresno, Imperial, Kern, Los Angeles, Orange, Placer, Sacramento, San Diego, San Francisco, San Mateo and Yolo — these together include more than three fifths of poor Californians.

Contact Information

San Francisco County's Health Consumer Center:

(415) 982-1300 Community Health Advocacy Project (CHAP)
 (415) 982-4243 San Francisco Office
 1035 Market Street, 5th Floor
 San Francisco, CA 94103

(415) 354-6360 Legal Advise Line

Web site <http://healthconsumer.org>

Resources

Family Violence Resources	
Phone	24-Hour Hotlines for Assistance/Shelter
(415) 474-4621	Raphael House
(415) 751-7110	Asian Women's Shelter (San Francisco)
(510) 538-0152	Deaf Women's Legal Program (TTY)
(877) 503-1850	La Casa de las Madres (San Francisco)
(415) 441-0123	Night Ministry
(877) 923-0700	Teen
(415) 864-4722	Woman, Inc. (San Francisco)
(800) 843-5200	Youth Crisis Line
(415) 255-0165	The Riley Center
(415) 441-KIDS	TALKLine Family Support Center
(415) 333-HELP	Community United Against Violence - Gay & Lesbian (San Francisco)
(800) 656-HOPE	National Sexual Assault Hotline
(800) 799-SAFE	National Domestic Violence Hotline
(800) 4A-CHILD	National Child Abuse Hotline
	Counseling
(415) 781-0401	Carmen House
(415) 777-5500	Community United Against Violence - Gay & Lesbian (San Francisco)
(415) 674-6023	Glide Women's Center
(877) 503-1850	La Casa de las Madres (San Francisco)
(415) 449-1200	Jewish Family & Childrens' Services
	Legal Assistance
(415) 567-6255	API Legal Outreach - Family Law & Immigration
(415) 354-6360	Bay Area Legal Aid - Divorce & Custody
(415) 255-0165	Cooperative Restraining Order Clinic (CROC)
(415) 863-3762	Legal Services for Children, Inc.
(415) 567-6255	Asian Pacific Islander Legal Outreach
	Sexual Violence
(415) 437-3000	San Francisco Rape Treatment and Trauma Recovery Center
(415) 647-7273	San Francisco Women Against Rape
	Victim Witness Services
(415) 553-9044	San Francisco County District Attorney's Office Victim Advocacy Svcs. Unit
	Batterers Intervention Program
(415) 553-1706	Probation Department - Adult Probation Department

Office of the Patient Advocate



Office of the Patient Advocate is an independent office under the State of California’s Business, Transportation, and Housing Agency. Established in July 2000, the Office **is responsible for protecting patient rights and works closely with the Department of Managed Health Care to ensure access to quality health care. Annual publication of the Quality of Care Report Card**

Services

The Office of the Patient Advocate educates people on how to obtain optimal care through their HMOs.

Contact
Information

(916) 324-6407 Office of the Patient Advocate
9th Street, Suite 500
(866) 466-8900 Sacramento, CA 95814

(888) 466-2219 Help Center
(877) 688-9891 (TTY)
(800) 854-7784 (Relay)

Web site <http://www.opa.ca.gov>

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Office of Clients' Rights Advocates (OCRA)



Office of Clients' Rights Advocates (OCRA) is a statewide program offering legal representation and training to people with developmental disabilities and their families. OCRA is operated by Disability Rights California (DRC - formerly Protection and Advocacy), a nonprofit agency that works in partnership with people with disabilities—to protect, advocate for and advance their human, legal, and service rights. [see Disability Rights CA information in Services this section]

OCRA lawyers are located at every Regional Center in California and provide free legal representation regarding service systems such as:

Contact Information

- ❑ Child Abuse
- ❑ Criminal justice system
- ❑ Guardianship
- ❑ In-Home Services
- ❑ Private Insurance
- ❑ Medi-Cal
- ❑ Mental Health
- ❑ Regional Centers
- ❑ Schools
- ❑ Social Security
- ❑ Other miscellaneous areas of law

(800) 390-7032 Office of Clients' Rights Advocates
email OCRAInfo@disabilityrightsca.org

(415) 499-9724 Golden Gate Regional Center OCRA
Contact: Katy Lusson, CRA

Web site <http://www.disabilityrightsca.org/OCRA>

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Procedural Safeguards and Referral Services (PSRS)



Procedural Safeguards and Referral Services (PSRS) provide technical assistance, information and resources on procedural safeguards and educational rights of students (3 up to age 22) with disabilities to parents, school districts, advocates, agencies and others. Services are offered through the California Department of Education/Special Education Division.

PSRS can provide:

Services

- Local dispute resolution to help families resolve their disputes with their school without having to go through the formal Compliance Complaint proceedings.
- Intake and investigation of formal Special Education Compliance Complaints related to violation of state and federal Individuals with Disabilities Act (IDEA) special education law. Some examples of non-compliance are:
 - The Individualized Education Plan (IEP) for a given student is not being implemented as specified in the student’s IEP, a legally-binding document.
 - Special Education Procedural Safeguards protecting the rights of a student and the parent/guardian were not protected as specified by state and federal special education law.
- Information to local school districts on the number and nature of complaints filed against them.

Contact Information	(800) 926-0648	Procedural Safeguards and Referral Services (PSRS)
	(916) 323-9779 TTY	1430 N Street, Suite 2401
	(916) 327-3704 FAX	Sacramento, CA 95814
Email	speceducation@cde.ca.gov	
Web info	http://www.cde.ca.gov/sp/se/fp	
	http://www.cde.ca.gov/sp/se	
Basic Parent Rights	http://www.cde.ca.gov/sp/se/qa/pssummary.asp	

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Respite Care

Respite care is a necessity for caregivers of children with special health care needs, but it can be difficult to find. Here is a selection of agencies which either provide care or contract with other agencies for the care.

Agencies

San Francisco County Agencies with Respite Care Services for Families		
Golden Gate Regional Center		
875 Stevenson Street - 6th Floor San Francisco, CA 94103		Intermittent relief to families who provide constant care and supervision to the consumer whose care needs are beyond that of persons without disabilities. Parents self refer.
Office: (415) 546-9222		
TDD: (415) 546-9222		
Fax: (415) 546-9203		
Web site www.ggrc.org		
In-Home Support Services (IHSS) Public Authority of San Francisco		
832 Folsom Street, 9th Floor San Francisco, CA 94107		Maintains a registry of available in-home care workers.
Office (415) 243-4477		
TDD: (415) 243-4430		
Fax: (415) 243-4407		
The Janet Pomeroy Center		
Office (415) 665-4100		Offers recreational and respite programs for children with disabilities.
Fax (415) 665-7543		
E-mail info@janetpomeroy.org		
Web site www.janetpomeroy.org		

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Agencies
(continued)

San Francisco County Agencies with Respite Care Services for Families		
FamilyPaths (formerly Parental Stress Service - PSS)		
Hotlines (24 hrs/7 days)	(510) 893-5444 (800) 829-3777	Provides short-term childcare placements (a few hours or overnight) for children (birth up to age 14) when parents or caregivers have an acute stress-related need for a break from the responsibilities of caring for their children. This service provides for the safety of the child/children while giving the parent/caregiver the opportunity to regain their ability to resume care. Parents self refer.
Web site	www.familypaths.org	
Family Support Services of the Bay Area		
410 Grand Avenue Oakland CA 94610		Provides in-home and out-of-home respite for daytime, overnight or multiple day stays. Serves parents (birth, adoptive and foster) and relative caregivers who are caring for children with special needs, for example, developmentally disabled, prenatally substance exposed, abused or neglected, HIV affected, or at risk of abuse or neglect. Referrals are from community-based organizations & from self referrals.
Respite Phone	(510) 834-4006	
Fax	(510) 834-4010	
Web site	www.fssba-oak.org	

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Educational & Developmental Services



- Q Office of Developmental Primary Care
- Q Early Start Prevention Resource and Referral Services (PRRS)
- Q Head Start
- Q Golden Gate Regional Center
- Q Section 504 of the Rehabilitation Act
- Q Special Education

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Office of Developmental Primary Care



The Office of Developmental Primary Care has benefited from partnerships with faculty across the University of California, San Francisco and from relationships with a variety of community agencies that serve people with developmental disabilities. We aim to expose students to models of interprofessional training. Some of our best teachers are the people who that we serve, their family members, and Caregivers.

Services At UCSF and SFGH

Family Health Center, located at San Francisco General Hospital, is the largest primary care clinic in San Francisco's Community Health Network, with almost 40,000 patient visits per year.

Multi-Disciplinary Assessment Clinic (MDAC), within the UCSF Department of Pediatrics and based at San Francisco General Hospital, provides developmental and behavioral evaluations for children ages 0-5 living in San Francisco, with funding provided by First 5 California. Children between ages 6-22 may also be seen at MDAC provided they live in San Francisco, have MediCal, and are pre-approved by their insurance providers.

Pediatric Screening Clinic, housed at San Francisco General Hospital, provides screening for developmental and behavioral concerns for SFGH primary care patients, ages 0-5. Students have the opportunity to practice administering the Ages & Stages Questionnaire (ASQ), the Ages & Stages Questionnaire-Social Emotional (ASQ-SE) and the Family Psychosocial Screener.

UCSF Adolescent & Young Adult Clinic provides comprehensive health care to adolescents and young adults.

UCSF Epilepsy Clinic cares for a large population of patients with medically-intractable epilepsy who have failed numerous previous epilepsy therapies.

UCSF General Internal Medicine Practice provides primary care services to adults, including health promotion, lifestyle risk reduction, and the management of common acute and chronic medical conditions.

Eligibility Who is eligible for Child Developmental and Behavioral Pediatrics services?

Children birth up to age 18 who have or are at risk for:

- Behavioral problems
- Developmental delay
- Developmental disabilities
- Learning problems

Referral Referrals are made by the child's primary care provider by contacting the intake coordinator.

Contact Information (415) 476-4641 UCSF Department of Family and Community Medicine
Intake Coordinator Office of Developmental Primary Care
(415) 476-6051 FAX
Web site <http://www.developmentalmedicine.ucsf.edu/odpc.html>

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Prevention Resources and Referral Services (PRRS)



Prevention Resources and Referral Services (PRRS) The PRRS program helps families traverse the joys and challenges of raising a child. Through the collaboration of local ESFRCs, Regional Centers and the PRRS program, families will be provided with information, resources and support services that will assist them in identifying and meeting their child's unique strengths and needs.

The developmental domains a Regional Center must consider are:

- q Communication
- q Cognitive
- q Physical
- q Social/Emotional
- q Self-help/Adaptive

Early Start

Services

Early Start services include:

- q Intake/Assessment, Service Coordination and Referrals
- q Therapy services (speech, physical and/or occupational therapy) not offered through the family's private insurance
- q Vision and hearing services not offered through the family's private insurance
- q Infant development programs
- q Medical services not offered through the family's private insurance
- q Parent support, counseling, respite and training
- q Nutrition/feeding services not offered through the family's private insurance
- q Assistive technology (AT), including assistive devices or services
- q Psychological and social work services not offered through the family's private insurance
- q Transportation and related costs necessary for a child to receive services

Early Start

Eligibility

In California, eligible children include an infant or toddler (under the age of three) who:

- q Has a significant delay of at least 33% in one developmental domain, if referred before 24 months of age.
- q Has a delay of at least 50% in one domain, or 33% in two domains, if referred after 24 months of age.
- q Has an established risk condition that may result in a developmental disability (for example: Down Syndrome, Cerebral Palsy, Epilepsy)

Prevention

Program

Services

Prevention Resource and Referral Services:

- q Intake/Assessment
- q Case Management (including Monitoring)
- q Referrals to generic agencies

In California, eligible children include an infant or toddler (under the age of three) who:

- q Is at high risk of having a developmental disability.
(ie., has at least two biomedical factors listed on the RCEB referral form)
- q Has parent(s) with developmental disabilities.
- q Is referred between 24 and 35 months and has a developmental delay in one domain of 33% through 49%.

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Prevention Program Eligibility	<p>How do you enroll?</p> <p>"Primary referral sources" are required to make referrals to appropriate public agencies such as Regional Center of the East Bay (RCEB). [see RCEB information in this section]</p> <p>"Primary referral sources" include:</p> <ul style="list-style-type: none">o Hospitalso Physicianso Other health care providerso Public health facilitieso Day care facilities
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Evaluation and assessment, eligibility determination and an Individualized Family Service Plan (IFSP) must all occur within 45 days of referral for children found eligible for the Early Start Program. For children found eligible for the Prevention Program, the timeline is 60 days and results in a Prevention Program Plan (PPP).

How are services delivered?

Early intervention services may be provided by school districts, local centers, public and private agencies that are all part of California's Early Start Program in your community. Where and how services are delivered is determined together by the family and early intervention team. For example, services may be provided in the home, at a center or agency program with other babies, in childcare or other natural settings.

PRRS program is administered by Support for Families of Children with Disabilities and services include:"

- Early Start eligibility is determined by the regional centers for all children with developmental concerns including those at-risk.
- If the child is not eligible for Early Start, the regional centers determine if a referral to PRRS is appropriate based on the child's risk factors.
- If appropriate for PRRS, and with parental consent, the regional center refers the family to the local ESFRC.
- ESFRCs will provide information, resources, referrals and follow-up to parents and caregivers of referred at-risk babies, birth to 36 months.

To contact the Early Start Family Resource Center in San Francisco is Support for Families of Children with Disabilities, please call Support for Families at our warmline at 415-920-4050 for more information.

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Head Start



Head Start's mission is to improve the lives of low income children (from birth through age 5) by providing quality comprehensive child development services that are family focused, including education, social, medical, dental, nutrition and mental health services. Early Head Start programs support the healthy development of children (from 0 up to age 3) by serving pregnant women, infants, toddlers and their families. Head Start supports children (from 3 through age 5) or until children typically enter elementary school.

Head Start receives 80% of funding from federal grants and 20% from cash or services contributed by communities. Grants are provided to non-profit organizations and school systems, which may establish priorities for enrolling children based on community needs and available funds. 10% of Head Start enrollment must be offered to children with disabilities.

Services There are four major components of Head Start services:

1. Health Care including medical care (exams, immunizations, health education), oral/dental health care, and mental health care
2. Nutrition Services (one third of daily nutritional needs)
3. Culturally-competent Education (including parent involvement)
4. Social Services (referral to other programs and resources)

Head Start Programs Eligibility	
Early Head Start	<ul style="list-style-type: none"> • Early Head Start serves low-income pregnant women and families with infants and toddlers (0 up to age 3). • Each program is responsible for determining its own eligibility criteria. • Federal poverty limit (FPL) guidelines are used to evaluate family income when determining eligibility. • Early Head Start programs may also elect to target services to a particular population to best meet the needs of families and children in their community.
Head Start	<ul style="list-style-type: none"> • Head Start serves children (3 through age 5) from families that meet federal poverty limit (FPL) guidelines. • Individual programs establish priorities for enrolling children based on community needs and available funds.

(415) 405-0500 Head Start San Francisco

(415) 552-7257

(916) 323-9727 CA Head Start State Collaboration Office

Web site <http://www.cde.ca.gov/sp/cd/re/chssco.asp>

(916) 444-7760 CA Head Start Association

Web site <http://caheadstart.org>

Early Head Start National Resource Center

Web site <http://www.ehsnrc.org>

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Golden Gate Regional Center

Golden Gate Regional Center (GGRC) is part of the Regional Center system in California; an entitlement program designed to serve individuals with developmental disabilities (regardless of income) and to assist their families. Regional Centers serve all ages, from newborns to seniors. Regional Centers are “payers of last resort” so they will not pay for services that can be funded through a different source (e.g. school district or private insurance). Each center has its own local Board of Trustees.

Services

What services are provided?

Regional Centers provide (or vendor) or coordinate the following services:

- Information and referral
- Assessment and diagnosis
- Counseling and Psychotherapy
- Lifelong individualized planning and service coordination
- Purchase of necessary services included in the Individual Program Plan (IPP)
- Assistance in finding and using community and other resources (including supported living and work)
- Advocacy for the protection of legal, civil and service rights
- Prevention services for at-risk infants and their families
- Early intervention services for for infants/toddlers with established risk condition or developmental delays/disabilities
- Genetic counseling
- Family support
- Planning, placement, and monitoring for 24-hour out-of-home care
- Training and educational opportunities for individuals and families (including mobility)
- Community education about developmental disabilities
- Respite (including nursing level care)
- Adult Day programs

Eligibility

Who is eligible?

Regional Center Eligibility Criteria	
Individuals with Disabilities	Individuals with disabilities are eligible for Regional Center services according to the following criteria: 1) the individual has one of the following diagnoses: mental retardation, cerebral palsy, epilepsy, autism or a condition requiring treatments similar to that required by persons with mental retardation; 2) the disability began before the age of 18; 3) the disability is likely to continue; and 4) is substantially disabling for the individual
Infants (0 up to 36 months)	[see Early Start and Prevention Program information in this section]

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Individuals applying for Regional Center services must go through an interdisciplinary evaluation process to determine their eligibility. Once an individual has been determined to be eligible for Regional Center services, they are considered a client of the system for life.

How do you enroll?

Referrals can be made at any time in the individual's life. Ideally, the earlier the individual is referred to the Regional Center, the sooner the individual can receive needed services and supports. Referrals can be made in a number of ways: through early intervention programs, referral from family, friends and professionals.

(415) 546-9222 Golden Gate Regional Center (GGRC)
(888) 339-3306 FAX 875 Stevenson Street, 6th Floor
San Francisco, CA 94103

Web site <http://www.ggrc.org>
(888) 339-3305 Early Start and Prevention Program Intake/Assessment

See binder section H for Modified Checklist for Autism in Toddlers (M-CHAT) forms in English and Spanish, including scoring.

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Section 504 of the Rehabilitation Act (in the school setting)

Section 504 of the Rehabilitation Act's purpose is to eliminate discrimination on the basis of disability in all programs and activities receiving federal financial assistance, which includes education. Section 504 guarantees students with disabilities equal access to services and opportunities available to all students, and to provide a free and appropriate public education (FAPE).

Responsible Person Each school district is required to have at least one person who is designated as the 504 Coordinator, who is responsible for ensuring that student needs are identified and that appropriate accommodations are instituted and provided.

504 Plan vs. an IEP If services and/or accommodations are indicated, an individualized 504 Plan is developed and implemented. The 504 eligibility process may be less structured than the Individualized Education Program (IEP) special education process under the Individuals with Disabilities Education Act (IDEA). And unlike an IEP, no funding is attached to 504 Plans. Funding for 504 Plans comes from the general school budget. IDEA funds may not be used to serve students who are served only with 504 Plans.

Enforcement If a school or agency is found to be out of compliance with Section 504, they could lose federal funding. Unlike IDEA compliance, which is monitored by the CA Department of Education (CDE), the U.S. Office for Civil Rights (OCR) enforces Section 504.

Services

504 Accommodations in the School Setting may include:

- Providing extra time for tests or assignments.
- Moving the student's desk to the front of the classroom so that the student can see the blackboard better, or hear or focus on the teacher adequately.
- Excusing the student so that he/she can do a fingerstick to check blood sugar, or providing health-related services to assist with blood sugar testing or provision of insulin.
- Reading test questions to a student. with visual or print disability. Providing a notetaker.
- Providing a job coach for adolescents or young adults in supported employment settings as part of their school to work learning experiences.
- Providing a quiet room for test taking.

Important Note: In elementary and secondary public school settings (unlike some other programs receiving federal dollars) the obligation to provide accommodations and/or services necessary to provide a free and appropriate public education (FAPE) under Section 504 is not subject to the limitations regarding undue financial and administrative burdens or fundamental alteration of the program.

Eligibility Who is eligible?

School-aged children (who may/or may not have a disability that meets special education IDEA criteria) who have:

- ◻ a physical or mental impairment which substantially limits a major life activity, or
- ◻ have a record of such an impairment, or
- ◻ are regarded as having an impairment

This includes students who have a mental or psychological disorder such as mental retardation, mental illness, emotional illness, a specific learning disorder or organic brain syndrome.

Eligibility (continued) Physical impairment refers to a physiologic disorder, contagious disease, cosmetic disfigurement or loss of one or more body systems.

Students with disabilities are protected by Section 504 regardless of whether the student is found eligible for special education programs and services in an IEP. Students eligible for special education services in an IEP are doubly protected by both 504 and IDEA laws.

Major life activities limited by either mental or physical impairment include:

- ◻ Self-care activities
- ◻ Walking
- ◻ Seeing
- ◻ Hearing
- ◻ Breathing
- ◻ Learning
- ◻ Ability to work
- ◻ Ability to do a manual task

Providers Where are services provided?

Broadly, Section 504 services and/or accommodations can be provided in the school, workplace and community, as appropriate.

Referral How to make a referral for Section 504 services:

Any school personnel or the parent/guardian can request determination for Section 504 by contacting the 504 Coordinator or principal at the student's home school. No student can receive a Section 504 Plan without the consent of the parent or legal guardian.

Contact Information Call your... Child's Home School Principal or District 504 Coordinator

For 504 Enforcement/Non-Compliance Issues:

(415) 437-8310 Office for Civil Rights
 (415) 437-8311 TDD Region IX (AZ/CA/HI/NV/Am. Samoa/Guam)
 (415) 437-8329 FAX U.S. Department of Health and Human Services
 50 United Nations Plaza – Room 322
 San Francisco, CA 94102

Web site <http://www.hhs.gov/ocr>

(510) 267-1200 Disability Rights CA (formerly Protection & Advocacy)
 (800) 776-5746

Web site <http://www.disabilityrightsca.org>

(510) 644-2555 Disability Rights Education & Defense Fund (DREDF)
 Parent Training & Information (PTI) Center
 Education Advocate can answer education-related questions pertaining to students with disabilities age 0-22.

Email iephelp@dredf.org

Web site <http://www.dredf.org>

Examples of Appropriate Accommodations Under Section 504 of the Rehabilitation Act of 1973

Source: Developed by the Office of Superintendent of Public Instruction (OSPI)

Section 504 Appropriate Accommodations Examples

Area of Concern	Accommodations
Parent/student/teacher communications	<ul style="list-style-type: none"> • Develop a daily/weekly journal. • Develop parent/student/school contacts. • Schedule periodic parent/teacher meetings. • Provide parents with duplicate sets of texts.
Difficulty sequencing and completing steps to accomplish specific tasks (writing a book report, term paper, organized paragraphs, division problems, etc.)	<ul style="list-style-type: none"> • Break up task into workable and obtainable steps. • Provide examples and specific steps to accomplish task.
Shifting from one completed activity to another without closure	<ul style="list-style-type: none"> • Define the requirements of a completed activity. (Your math is finished when all 6 problems are complete and corrected; do not begin on the next task until it is finished.)
Difficulty following through on instructions from others	<ul style="list-style-type: none"> • Gain student's attention before giving directions. Use alerting cues. Accompany oral directions with written directions. • Give one direction at a time. Quietly repeat directions to the student after they have been given to the rest of the class. Check for understanding by having the student repeat the directions. • Place general methods of operation and expectations on charts displayed around the room and/or on sheets to be included in student's notebook.
Difficulty prioritizing from most to least important	<ul style="list-style-type: none"> • Prioritize assignments and activities. • Provide a model to help students. Post the model and refer to it often.
Difficulty sustaining effort and accuracy over time	<ul style="list-style-type: none"> • Reduce assignment length and strive for quality (rather than quantity). • Increase the frequency of positive reinforcement (catch the student doing it right and let him know it).
Difficulty completing assignments	<ul style="list-style-type: none"> • List and/or post (and say) all steps necessary to complete each assignment. • Reduce the assignment into manageable sections with specific due dates. • Make frequent checks for work/assignment completion. • Arrange for the student to have a "study buddy" with phone number in each subject area.

Section 504
Examples
(continued)

Area of Concern	Accommodations
Difficulty with test taking	<ul style="list-style-type: none"> • Allow extra time for resting, teach test-taking skills and strategies, and allow student to be tested orally. • Use clear, readable and uncluttered test forms. Use test format that the student is most comfortable with. Allow ample space for student response. Consider having lined answer spaces for essay or short answer questions.
Confusion from non-verbal clues (misreads body language, etc.)	<ul style="list-style-type: none"> • Directly teach (tell the student) what non-verbal cues mean. Model and have student practice reading cues in a safe setting.
Confusion from written material (difficulty finding main idea from a paragraph, attributes greater importance to minor details)	<ul style="list-style-type: none"> • Provide student with copy of reading material with main ideas underlined or highlighted. • Provide an outline of important points from reading material. • Teach outlining, main ideas/details concepts. • Provide tape of text/chapter.
Confusion from spoken material, lectures and audio-visual material (difficulty finding main idea from presentation, attributes greater importance to minor details)	<ul style="list-style-type: none"> • Provide student with a copy of presentation notes. • Allow peers to share notes from presentation (have student compare own notes with copy of peer's notes). • Provide framed outlines of presentations (introducing visual and auditory cues to important information). • Encourage the use of tape recorder. • Teach and emphasize key words (the following is the most important point , etc.).
Difficulty sustaining attention to tasks or other activities (easily distracted by extraneous stimuli)	<ul style="list-style-type: none"> • Reward attention. • Break up activities into small units. • Reward for timely accomplishments. • Use physical proximity and touch. • Use earphones and/or study carrels, quiet place, or preferential seating.
Frequent messiness or sloppiness (continued on next page)	<ul style="list-style-type: none"> • Teach organizational skills. Be sure student has daily, weekly and/or monthly assignment sheets, list of materials needed daily, and consistent format for papers. Have a consistent way for students to turn in and receive back papers, reduce distractions. • Give reward points for notebook checks and proper paper format. • Provide clear copies of worksheets and handouts and consistent format for worksheets. Establish a daily routine, provide for what you want the student to do.

Section 504
Appropriate
Accommodations
Examples
(continued)

Area of Concern	Accommodations
Frequent messiness or sloppiness... (continued from previous page)	<ul style="list-style-type: none"> • Arrange for a peer who will help with organization. • Assist student to keep materials in a specific place (pencils and pens in pouch). • Be willing to repeat expectations.
Poor handwriting	<ul style="list-style-type: none"> • Allow for a scribe and grade for content, not handwriting. Allow for use of a computer or typewriter. • Consider alternative methods for student response (tape recorder, oral reports, etc.). • Don't penalize student for mixing cursive and manuscript (accept any method of production).
Very slow and laborious handwriting	<ul style="list-style-type: none"> • Allow for shorter assignments (quality versus quantity). • Allow alternative method of production (computer, scribe, oral presentation, etc.).
Poorly developed study skills	<ul style="list-style-type: none"> • Teach study skills specific to the subject area—organization (assignment calendar), textbook reading, note taking (finding main idea/detail, mapping, outlining, skimming, summarizing).
Poor self-monitoring (careless errors in spelling, arithmetic, reading)	<ul style="list-style-type: none"> • Teach specific methods of self-monitoring (stop, look, listen). • Have student proofread work when some time has passed.
Low fluency or production of written material (takes hours on a 10 minute assignment)	<ul style="list-style-type: none"> • Allow for alternative method of completing assignment (oral presentation, taped report, visual presentation, graphs, maps, pictures, etc.) with reduced written requirements. • Allow for alternative method of writing (typewriter, computer, cursive or printing, or a scribe).
Apparent inattention (underactive, daydreaming, doesn't seem to be there)	<ul style="list-style-type: none"> • Get student's attention before giving directions. Tell student how to pay attention (Look at me while I talk; watch my eyes while I speak). Ask student to repeat directions. • Attempt to actively involve student in lesson (cooperative learning).
Difficulty participating in class without interrupting, difficulty working quietly	<ul style="list-style-type: none"> • Seat student in close proximity to teacher. • Reward appropriate behavior (catch student "being good"). • Use study carrel if appropriate.
Inappropriate seeking of attention (clowns around, exhibits loud excessive or exaggerated movement as attention-seeking behavior, interrupts, butts into other children's activities, needles others)	<ul style="list-style-type: none"> • Show student (model) how to gain other's attention appropriately. • Catch the student being appropriate and reinforce.

Section 504
Examples
(continued)

Area of Concern	Accommodations
Frequent excessive talking	<ul style="list-style-type: none"> • Teach student hand signals and use to tell student when to talk and when not to. • Make sure student is called upon when it is appropriate and reinforce listening.
Difficulty making transitions	<ul style="list-style-type: none"> • Program student for transitions. Give advance warning of when a transition is going to take place (Now we are completing the worksheet, next we will...) and the expectations for the transition (and you will need...). • Specifically say and display list of materials needed until a routine is possible. List steps necessary to complete each assignment. • Have specific locations for all materials (pencil pouches, tabs in notebooks, etc.). • Arrange for an organized helper (peer).
Difficulty remaining seated or in a particular position when required	<ul style="list-style-type: none"> • Give student frequent opportunities to get up and move around. Allow space for movement.
Frequent fidgeting with hands, feet or objects; squirming in the seat	<ul style="list-style-type: none"> • Break tasks down to small increments and give frequent positive reinforcement for accomplishments (this type of behavior is often due to frustration). • Allow alternative movement when possible.
Inappropriate responses in class often blurted out; answers given to questions before they have been completed	<ul style="list-style-type: none"> • Seat student in close proximity to teacher so that visual and physical monitoring of student behavior can be done by teacher. • State behavior that you do want (tell the student how you expect him to behave).
Losing things necessary for task or activities at school or at home (pencils, books, assignments before, during and after completion of a given task)	<ul style="list-style-type: none"> • Help student organize. Frequently monitor notebook and dividers, pencil pouch, locker, book bag, desks. A place for everything and everything in its place. • Provide positive reinforcement for good organization. Provide student with a list of needed materials and their locations.
Poor use of time (sitting, staring off into space, doodling, not working on task at hand)	<ul style="list-style-type: none"> • Teach reminder cues (a gentle touch on the shoulder, hand signal, etc.). • Tell the student your expectation of what paying attention looks like (You look like you're paying attention when....). • Give the student a time limit for a small unit of work with positive reinforcement for accurate completion. • Use a contract, timer, etc. for self-monitoring.
Modification of classroom/building climate to accommodate student needs	<ul style="list-style-type: none"> • Use air purifier. • Control temperature. • Accommodate specific allergic reactions.

Section 504
Appropriate
Accommodations
Examples
(continued)

Area of Concern	Accommodations
Modification of classroom/building to accommodate equipment needs.	<ul style="list-style-type: none"> • Plan for evacuation for wheelchair-using students. • Schedule classes in accessible areas.
Building health/safety procedures	<ul style="list-style-type: none"> • Administer medication. • Apply universal precautions. • Accommodate special diets.
District policies/procedures	<ul style="list-style-type: none"> • Allow increase in number of excused absences for health reasons. • Adjust transportation/parking arrangements. • Approve early dismissal for service agency appointments.
Staff communications	<ul style="list-style-type: none"> • Identify resource staff. • Network with other staff. • Schedule building team meetings. • Maintain ongoing communication with building principal.
School/community/agency communication	<ul style="list-style-type: none"> • Identify and communicate with appropriate personnel working with student. • Assist in agency referrals. • Provide appropriate carryover in the school environment.
Agitation under pressure and competition (athletic or academic)	<ul style="list-style-type: none"> • Stress effort and enjoyment for self, rather than competition with others. • Minimize timed activities; structure class for team effort and cooperation.
Inappropriate behaviors in a team or large group sport or athletic activity (difficulty waiting turn in games or group situations)	<ul style="list-style-type: none"> • Give the student a responsible job (team captain, care and distribution of balls, scorekeeping, etc.); consider leadership role. • Have student in close proximity to teacher.
Frequent involvement in physically dangerous activities without considering possible consequences.	<ul style="list-style-type: none"> • Anticipate dangerous situations and plan for in advance. • Stress Stop-Look-Listen. • Pair with responsible peer. (Rotate responsible students so that they don't wear out!)
Poor adult interactions, defies authority, clings, too eager to please	<ul style="list-style-type: none"> • Provide positive attention. • Talk with student individually about the inappropriate behavior (A better way of getting what you want is....).
Frequent self-putdowns, poor personal care and posture, negative comments about self and others, low self-esteem	<ul style="list-style-type: none"> • Structure for success. • Train student for self-monitoring, reinforce improvements, teach self-questioning strategies (What am I doing? How is that going to affect others?). • Allow opportunities for the student to show his strength. • Give positive recognition.

Section 504
Examples
(continued)

Area of Concern	Accommodations
Difficulty using unstructured time — recess, hallways, lunchroom, locker room, library, assembly	<ul style="list-style-type: none">• Provide student with a definite purpose during unstructured activities. (The purpose of going to the library is...)• Encourage group games and participation.

Special Education

Special Education is instruction individually designed to meet the unique needs of children with disabilities. It provides them with a “free appropriate public education” (FAPE) in the “least restrictive environment” (LRE) as guaranteed by the federal Individuals with Disabilities Education Act (IDEA).

Included in special education are the services and supports that are needed by students whose educational needs cannot be met by simple modification of the regular instructional program. Education for children with disabilities may include independent living skills or specialized therapies or services in addition to academics.

Parents/guardians are full members of the Individualized Education Program (IEP) team. No planning or provision of special education services can be provided without the participation (if desired) and consent of the parent/guardian or person who holds Educational Rights, if this person is not the parent.

What services are provided?

Special Education Services	
Individualized Education Program (IEP) Process	
<ul style="list-style-type: none"> • Identification of children with special needs. • Assessment and Triennial (every 3 years) Reassessment by appropriate disciplines to determine eligibility and identify needed services. • Annual development (or more often as necessary) of the student’s IEP plan to provide necessary specialized instruction and related services. • Evaluation of goals and modification of educational plan as needed. 	
Related Services (may include but are not limited to)	
<ul style="list-style-type: none"> • 1:1 Instructional Aide (IA) • Adapted Physical Education (APE) • Art Therapy • Assistive Technology (AT) • Audiology services • Counseling and Guidance • Diagnostic Medical Services • Health and Nursing services • Home or Hospital Instruction • Low-incidence Disabilities specialized services, such as readers, transcribers, and vision and hearing services • Occupational Therapy (OT) • Orientation and Mobility instruction • Parent Counseling and Training 	<ul style="list-style-type: none"> • Physical Therapy (PT) • Recreation, including therapeutic recreation • Rehabilitative Counseling Services • Sign Language or Oral Interpreter • Social Work services • Speech and Language development and remediation (SP) • Transportation • Vision services (VI) • Vocational specially designed Education and Career Development • Psychological services (in addition to assessment and development of the individualized education program) • Psychotherapy
All services are provided without cost to the family.	

Where are special education services provided?

Where special education services will be provided, usually called “placement,” is determined after the IEP team has fully considered all of the student’s needs. IEP services and placement are decisions all members of the IEP team must agree with.

Special Education Placement (continued)	<p>Specialized education and services may be provided in a variety of settings, including:</p> <ul style="list-style-type: none"> ◦ General Education classroom (with necessary supports)—often referred to as “full-inclusion” (FI) or “mainstreaming” ◦ Resource room (RS), or “push-in” or “pull-out” by specialists to other settings ◦ Special Day Class (SDC) on a regular campus ◦ “Non-public School” (NPS), a private therapeutic school that is credentialed by the state and eligible to receive district funding, or ◦ Combination of settings depending on the student’s individualized needs. ◦ Home, hospital, or residential treatment facility may also be necessary. <p>However, a key component of federal IDEA law mandates that children should receive special education services in the “least restrictive environment” (LRE), or most “natural” setting possible with necessary supports provided to the student in the LRE.</p>
Eligibility	<p>Who is eligible?</p> <p>A child must have a disability that aligns with at least one of the following categories:</p> <ul style="list-style-type: none"> ◦ Autism or autistic-like ◦ Deafness ◦ Deaf-blindness ◦ Hearing impairment ◦ Mental retardation ◦ Multiple disabilities ◦ Orthopedic impairment <p>In addition to having a disability satisfying at least one qualifying category, comprehensive assessment in all areas of suspected disability further determines eligibility. Having a qualifying disability does not automatically determine special education eligibility.</p> <p>Children from birth up to age 3 may qualify for IDEA Part C Early Intervention services. Children age 3 up to age 22 may qualify for IDEA Part B Special Education services provided by the local school district. Exception: a special education student who is found through comprehensive evaluation to no longer qualify for special education services (“exiting”), or a special education student who has earned a regular high school diploma is no longer eligible for special education and therefore may exit before age 22.</p>
Evaluation Request	<p>How does a person begin the IEP Process?</p> <p>A parent generally initiates a request to be evaluated for special education services. But teachers, Regional Center, or even a doctor can request that a student be evaluated. A request for special education evaluation must be made in writing and may be sent to the child’s teacher, the principal of the child’s home school, the school district’s Special Education Director, or all. Schools have an affirmative obligation to assess in order to locate children who may need special education; this is called “child find” in IDEA law.</p>
Timelines/ Procedure	<p>How must the school district respond to a request for special education evaluation?</p> <ul style="list-style-type: none"> ◦ From the date the written request for evaluation is received, the district has 15 calendar days (including weekend days but not counting days of school breaks in excess of 5 school days from the date of receipt of the referral) to provide a written Assessment Plan for parent consent. ◦ Parent/guardian may take 15 additional calendar days to ask any questions they may have before consenting to the Assessment Plan. Students cannot be assessed without the written consent of the parent or legal guardian. ◦ From date of consent, the school district has 60 calendar days to complete the assessments and hold the eligibility IEP meeting.



IEP Request If the student qualifies for special education services, as determined by the IEP team, the IEP meeting will continue in order to address the child's unique needs and a plan, the Individualized Education Plan (IEP) is developed to meet these needs. The parent/legal guardian is a full participant in the development of this legally-binding document and must consent to it in order for the IEP to be implemented. Sometimes there are disagreements and parents have many rights in this process.

An IEP meeting must be held at least annually. Parents of students currently receiving Special Education services have the right to request an IEP meeting to review or change the IEP at any time needed, however. The request for an IEP meeting must be made in writing. If the parent is not requesting additional assessment(s) at that time, the district must schedule an IEP within 30 calendar days of receiving a written request. Under IDEA 2004 reauthorization, an IEP can be amended without a full IEP meeting for smaller issues, if parents and districts both agree.

Special Education Contact Information

(415) 241-6085
www.sfusd.edu

School District Departments of Special Education:
San Francisco Unified School District
Department of Special Education

(916) 445-4613 CA Dept. of Education (CDE) / Special Education Division
(916) 323-9779 TTY 1430 N Street, Suite 2401
(916) 327-3516 FAX Sacramento, CA 95814
Web site <http://www.cde.ca.gov/sp/se>

(800) 926-0648 Procedural Safeguards and Referral Services (PSRS)
(916) 327-3704 FAX CDE information and referral on special education rights.
Intake for special education compliance complaints.

(510) 644-2555 Disability Rights Education & Defense Fund (DREDF)
Parent Training & Information (PTI) - Education Advocates
email iephelp@dredf.org
Web site <http://www.dredf.org>

(510) 267-1200 Disability Rights CA (DRC) (formerly Protection & Advocacy)
(800) 776-5746 "Special Education Rights & Responsibilities" (SERR) book
SERR book <http://www.disabilityrightscsca.org/pubs/504001SpecEdIndex.htm>

Co-Author Community Alliance for Special Education (CASE)
SERR Book
(415) 431-2285
www.caseadvocacy.org

How to

How do I file a Compliance Complaint with the CA Dept. of Education?**What is a Compliance Complaint?**

If a student with disabilities is not receiving the special education or related services specified in the student's IEP, including transport to therapy, a compliance complaint may be filed with the California Department of Education (CDE). The CDE must directly intervene (and not simply refer the complaint to the local educational agency (LEA, the school district) for self-investigation).

Where do I file a Compliance Complaint?

Write to:
Complaint Management and Mediation Unit
Special Education Division
California State Department of Education
1430 N Street, Suite 2401
Sacramento, CA 95814

Sample
Letter

Here is some simple wording for the complaint letter:

The Date you send your letter

Your Name, Your Address

Phone Number(s) where you can be reached in the daytime

Dear Sir or Madam:

This is a special education compliance complaint. I feel that the (School District Name) Unified School District is out of compliance with federal and state special education laws.

My child's name is (Child's Name), and he/she is (Child's Age) years old.

(Briefly describe your child's disability for which special education service(s) are needed, for example:) He/she has physical disabilities that require regular and on-going therapy through the California Children's Service program.

(Describe the service(s) agreed to in your child's IEP that is not being provided by your child's school district, for example:) Both the frequency of therapy and the mode of transportation to therapy are specified in my child's IEP. The district is failing to implement the IEP by refusing to provide transportation to and from therapy.

Failure to implement the IEP, [Cal. Ed. Code Sec. 56345] and to provide transportation as a related service, [34 C.F.R. Sec. 300.24 (b) (15); Cal. Ed. Code Sec. 56363; 5 C.C.R. Sec. 3051] are at issue. (It is not necessary to know the specific educational codes for which the school district is out of compliance, but you may include them if you know them.)

I have enclosed a copy of my child's IEP and the goals for these related services are highlighted. I ask for immediate investigation and resolution, as my child cannot afford to wait for these services. (Enclose a copy of the current IEP in force for your child and highlight the areas the complaint is about. Also keep a highlighted copy and a copy of your letter for yourself!)

Thank you for your assistance.

Your Signature



- Q Adolescent Health Transition Project (AHTP)
 - For Providers & Educators
 - For Parents & Families
 - Health History Summary
 - Transition Timeline
 - For Teens & Young Adults
 - Autonomy Checklists
- Q Department of Rehabilitation (DOR)
- Q Disabled Students Programs and Services (DSPS)
- Q Regional Occupational Centers and Programs (ROCP)
- Q WorkAbility Programs

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Adolescent Health Transition Project (AHTP)



Adolescent Health Transition Project (AHTP) is a resource for adolescents with special health care needs, chronic illnesses, physical or developmental disabilities. As adolescents become adults, they must assume responsibility for their health care. Assuming responsibility for one's own health care, as developmentally able, is part of growing up, becoming independent from one's family, and finding a place in the adult community.

Introduction However, adolescents with special health care needs, chronic illnesses, physical or developmental disabilities, may find this difficult. It's often hard to find an adult care provider trained in pediatric conditions or willing to assume primary responsibility. An adolescent who has been receiving care from a family practitioner may stay with that family practitioner and find it easy to continue to function in a child's role. Either way, young people may be uncomfortable in the role of adult health care consumer and families may have trouble letting go.

The Adolescent Health Transition Project is designed to help smooth the transition from pediatric to adult health care for adolescents with special health care needs.

Contact Information	Web site (AHTP)	http://depts.washington.edu/healthtr/index.html
	Providers/Educators	http://depts.washington.edu/healthtr/Providers/intro.htm
	Transition Timeline	http://depts.washington.edu/healthtr/resources/tools.others.html
	Teens Health Skills Checklist	http://depts.washington.edu/healthtr/resources/tools/checklists.html

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Approximately 8.6 million children in the U.S. (ages 10 to 17) have a disability. Of these, 16%, or 1.4 million, experience limitations in their activities and will probably have difficulty making the transition to adult health care.

Several reasons for this difficulty are consistently identified:

- Difficulty finding an adult health care provider who has been trained in pediatric conditions or who is willing to assume primary responsibility.
- Inadequate resources to deliver appropriate care within systems of adult health care.
- Lack of medical history available for the adult caregiver.
- Families unwilling to let go of primary health care responsibility.
- Young people finding their new role as adult health care consumer difficult.
- Family practitioner finding it difficult to begin viewing the client as a young adult.

When the health care delivery system acknowledges and endorses age-appropriate independence and social maturation, it encourages adolescents to come to terms with their conditions. This support helps them take responsibility for themselves and their care, rather than remain in more dependent relationships. Ideally, a medical transition will catalyze other adolescent transitions and support overall developmental progress.

Helping Families Address Long-Range Plans

Providers need to address health transitions with families of children with special health care needs as early as possible. What about when the child reaches school age, approaches adolescence, moves into adulthood? Adolescents with chronic illness and disabilities need to learn not only basic health skills, but also particular health skills related to their illnesses or disabilities. They should be encouraged to practice these skills while they still have the safety net of home and familiar health care providers.

However, it can be hard for families to address long-range plans for their children's health care when they're just trying to make it through each day. Professionals can look for times when life is less stressful for a family, and begin to prepare the family for a vision of their children as adults. It's important for the professional to let the family know that he or she acknowledges and understands the stress of raising a child with chronic illness or disability. Families should be encouraged to live one day at a time, but plan for the future as well.

AHTP
Providers &
Educators
(continued)**Deciding to Transfer the Child from Pediatric to Age-appropriate Adult Care**

All people are entitled to receive health care in age-appropriate settings, which promote autonomy and enrich social growth. Most adolescents with chronic illnesses or disabilities have much to gain from a timely move to age-appropriate health care or from receiving age-appropriate care from their family practitioner. Health care providers should advocate self-empowerment and full societal participation for their young adult clients. This self-reliance includes obtaining health care typically provided in an adult setting.

In the absence of a clear milestone, the decision to transfer care from the pediatric to the adult health care setting should be made by consulting with the patient and family. Successful transition will require that patients have a functional understanding of their conditions and have developed some self-care skills. Maturity, emotional stability, psychosocial development, and compliance are other factors to be considered in developing a timetable for transition. Transition should be timed to precede the inevitable attrition imposed by institutional mandates, the decrees of third-party payers, or abrupt patient or family demands. If possible, health care transition should occur at a time of relatively stable health.

The adolescent moving into the adult health care system should be offered different options, and should play an integral role in making decisions. Parents and families should be helped to understand their changing roles as the focus moves away from the family's presence at consultation and appointments, and toward health care providers speaking with the adolescent alone as much as possible.

AHTP Transition Tips for Providers

Providers & Educators
(continued)



One-on-One with the Young Client

- In health care settings, a parent is frequently asked to speak for a child, even when the child can speak for him or herself. If the child is able to speak and answer, address him or her directly. Ask the child about his or her needs and preferences, and let the child know you respect them. This gives the young person an opportunity to assume some personal responsibility for health and wellness.
- As children grow, check their perception of their disability or chronic illness from time to time. Then, help them fill in the gaps in their understanding. This understanding becomes increasingly important as children become adults and begin assuming responsibility for managing their own health care.
- Take a holistic perspective that combines typical health and development issues with those specific to the person.
- Provide condition-specific information at appropriate developmental stages, points of transition, and when the person is ready or needing to hear it. It may be necessary to review the same information several times. Information packages should include videotapes and interactive media as well as printed material. The material should also include information on support groups.
- Provide resource lists, referral sources, and opportunities to learn about alternatives.
- Train health care technicians in appropriate handling and communication techniques for persons with disabilities.

One-on-One with the Family

- Transition to age-appropriate adult health care is a process, not a single event. It involves the entire family. The actual process of transition should be gradual, occurring in concert with adolescent and family development.
- The process of parents gradually letting go of the care of their children is critical to the adolescent years. These teens, who will soon be young adults, will take charge of their own lives—including their health. Adolescents with disabilities face the developmental tasks that any adolescent faces, but their struggles may be intensified because of the disability. Health care providers should realize that the letting-go process is probably more difficult for the teen with chronic illness or disability and their families. Patience and empathy are necessary when dealing with these clients.
- As the teen approaches adulthood, his or her funding may change. Discuss the adolescent's funding options with the family. This should begin before age 17, as many adolescents lose their family's coverage at age 18. If a child needs ongoing care throughout his or her lifetime, questions about long-range care options need to be addressed right away. The possibility of not being able to care for their child is extraordinarily stressful for families; it's best to begin work on long-range plans early.
- Sexuality is a subject often ignored by parents and professionals. Many people are uncomfortable talking about sexuality, especially when a disability is involved. However, with an adolescent patient, the subject cannot be overlooked.
- Provide resource lists, referral sources, and opportunities to learn about alternatives.
- Provide families with an opportunity to use peer counseling and other families as resources.
- Be sure adults become aware of new assistive technology that may be better than methods used previously.

AHTP Providers & Educators (continued)

A Setting for Effective Transition

Provide a single point of entry to a system that coordinates the needed care. Effective clinics feature multiple disciplines and plenty of information on useful resources. Staff members show respect for individual decisions and acknowledge when more knowledge is needed to make informed decisions about care options.

Pediatric care providers should also facilitate appropriate transitions to adult care. Specialists should educate non-specialist professionals about how to manage the care of persons with disabilities, including appropriate sources for consultation.

Three Suggestions From the Adolescent Transition Program

In the final report of the Adolescent Transition Program (1988-1992), these three actions taken by health professionals were cited as very helpful to transitioning youths:

1. Give a teaching physical exam.

In it, the young person receives information about his or her physical status, special problems, and care needs. This exam helps ensure that the young person knows his or her strengths, weaknesses, and needs.

2. Compile a comprehensive health history.

Summarize pertinent medical information from childhood, to be passed on to adult care providers. While some youth may continue with their family practitioner, this summary will help the youth in case emergency care with a different adult provider is necessary. If the youth is transferring from pediatric care, this summary eliminates the need to transfer lengthy medical records.

3. Recommend support groups.

Groups that encourage these young people to discuss issues and concerns about their health care provide an opportunity to develop self-confidence and skills. They also broaden the young person's support network.

AHTP A Special Word To Educators
 Providers & Educators During the transition years, parents and educators are planning for the future with and for their youth with special needs. They consider education and training, housing, employment and recreation. However,
 (continued)

“often health issues are avoided—such issues as medications, treatments, appointments, general health maintenance, sexuality, communication with health professionals, and self advocacy in health care. Health is not a part of the usual transition plan, despite the fact that it has an influence over all the other parts of the transition.”

—Speak Up for Health: Planning for Self Advocacy in Health Care

Health Goals in the IEP/ITP For teens with Individualized Education Plans (IEPs), health goals can be included in the goals for transition, and health goals may be included in a child’s IEP early on. [see the Health Skills Checklists & Autonomy Checklists in this section, for ideas for health goals.] School nurses can be included as members of the school transition team, even if they have not been involved with a teen before. The teen’s health care provider and/or public health nurse may also be included on the school transition team.

School nurses, psychologists, and/or counselors may want to organize support groups for teens without IEPs. Or, they could provide information to families and students via school communication systems (such as school newsletters) regarding support groups in the community for specific disabilities and regarding disability entitlements and services. For example, the California Department of Rehabilitation provides a joint program with educators in the state to provide DR services, known as “WorkAbility.” [see WorkAbility information in this section of binder] Counselors are available to students with disabilities to help them determine future work goals and to provide and help identify services that will enable students to reach those work goals.

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AHTP Thinking about the Future: Parents & Families Information for Parents and Families



As a parent or family member of a child with special health care needs, you're probably caught up in day-to-day survival. You may wonder, "How can I think about tomorrow when I'm just trying to make it through today?" However, in those moments when you can catch your breath, it's helpful to be aware of your child's transitions and to think about the future.

Giving Your Child an Active Role in His or Her Health Care

Children need to play an active role in meeting their health care needs. As your child gets older, his or her role will get larger, and you will need to do less. Teenagers should be able to handle most of their own health care needs. Your goal as a parent is to work yourself out of the job of direct care provider. Although your emotionally supportive relationship continues, an adult child needs to manage his or her own life.

Elementary School

Starting when your child is young can make the transition easier.

When your child is in elementary school, you should do the following:

- Talk to your child about his or her chronic illness or disability, so he or she is able to tell others about it.
- Teach your child any danger signs associated with the illness or disability.
- Teach your child to take his or her medicine (you'll still need to track how much is taken).
- Teach your child specific self care for the illness or disability, such as proper rest, managing pain, and proper nutrition and hydration.
- Encourage your child to talk to the doctor and other health care providers, and to ask questions.

Adolescence

When your child is an adolescent, build on these skills by doing the following:

- Reassess your teen's knowledge of the chronic illness or disability and fill in any gaps in his or her understanding.
- Teach your teen to call the doctor if he or she experiences a danger sign associated with the illness or disability, and to tell you about it as well.
- Teach your teen to take his or her own medicine and to tell you how much is taken.
- Discuss the long-term course of the illness or disability with your teen, and what he or she might expect in the future.
- Teach your teen to go to doctor visits without you. Encourage your teen to communicate directly with the doctor and other health care providers, and to ask questions.
- Teach your teen to take his or her own temperature.
- Teach your teen to manage specific self-care.
- Encourage your teen to go to a teen support group.
- Encourage your teen to talk to a genetic counselor if appropriate.
- Encourage your teen to keep you informed about what he or she is doing and feeling.

AHTP Parents & Families (continued)

Teaching Your Child Basic Life and Independent Living Skills

It's never too early to start teaching your child these problem-solving and management skills. It's also important to give your child ample opportunities to practice them. These life skills must be rooted in knowledge, attitudes, and behavior. They include:

- Time management
- Energy management
- Handling money
- Stress management and coping skills (spiritual self-care, how to handle teasing)
- How to access information and resources
- The ability to be an assertive, effective advocate on one's behalf
- Self-care techniques related to daily living activities
- Development of social life
- Health and wellness care, including nutrition and fitness, personal safety, and self-defense.

Introducing Work, Responsibility and Earning Money

In general, career or vocational planning for a child with a disability is similar to that for a child without disabilities.

Vocational training and employment for your child will depend on employment support services available in your area, availability of assistive technology, accommodations made by the employer, and local economic climate. Keep in mind that work may be either volunteer or paid employment. It may take place either in an integrated work setting, or in a separate setting with other people with disabilities.

Teens going on to post-secondary education before starting their careers should be aware that most colleges have disability student services. [see Disabled Student Programs and Services (DSPS) information in this section] The disability student services office on campus can help students identify any accommodations they may need to be successful in college. For example, a student with a learning disability may benefit from someone who is assigned to take notes for him or her; a student with ADHD may be allowed a longer time to take tests; a student with blindness may need all texts provided in Braille.

Some Tips for Parents

- Assign your child chores at an early stage, as appropriate for his or her ability level.
- Begin to help your child learn independent living skills at an early age.
- Examine and consider your child's interests.
- Be aware that your child's interests and abilities will change, and so plans for work may change.
- Talk to a special educator or counselor who has training or experience in employment issues.
- Make sure that independent living and vocational skills are listed in your child's IEP if he or she receives special education services.

AHTP
Parents &
Families
(continued)

Recording Major Events in Your Child's Life

Maintain a journal or life record of the major events in your child's life. Review this record periodically. Share the record with your child, and give it to him or her during adolescence, or at an age-appropriate time.

Your Child's Life Record should include:

- Health issues or problems.
- Major developmental milestones.
- Major changes in family structure or dynamics.
- Therapy and service record. (Include provider and type of service)
- Equipment and vendors.
- Changes in function.
- Ongoing concerns.
- Assessments and formal reports, such as Individualized Education Plans (IEPs), Individualized Family Service Plans (IFSPs), Individualized Transitional Plans (ITPs), Individualized Program Plans (IPPs).
- Financial and Insurance information, such as trust funds and Social Security Insurance.
- Legal matters, such as living wills.

Family Members as Role Models

Parents and other family members are role models for a child at all ages. Remember that your actions (or lack of action) teach your child. You need to take good care of yourself! Set a healthy example in these areas:

- Fitness and exercise
- Personal care
- Education
- Self-esteem and pride
- Empowerment
- Advocacy for services and equipment
- Educating professionals and practitioners
- Refusing to be a victim of violence, crime, and substance abuse

AHTP Health History Summary “How-To” for Parents/Teens

Health History Summary “How-To”

How to Use the Health History Summary (following)

Young adults with special needs are often unsure about which health information of an often-lengthy health history they need to share with a new health care provider. The Health History Summary form for teens and their parents distills the most important facts in the teenager’s medical record. In addition to the general health history, the information covered includes medications taken, names of providers, surgeries and other significant health events, as well as family health history.

Youths and their families who have used this health history summary needed about 30–45 minutes to complete the information. It can be completed by the teen and his/her parents together. If completed yearly, teens learn more about their general health and specific special health need. It helps teens with special needs learn what is most important about their health and provides opportunities to ask parents and health providers for more information.

Parents find they better understand how much their child knows about their condition and are guided in what to teach their teen. Teens learn how to access information and how to articulate their knowledge of their condition. In addition, the collaboration on the health history summary helps parents to de-program themselves from filling out all the paperwork!

Our suggestions for successful use of the Health History Summary:

1. Begin in early teen years to complete a summary at least annually
2. Modify the health history summary whenever you experience a major health event or a change in medication type or dosage.
3. Complete the form as a parent-child team, moving more responsibility to the teen for completion whenever reasonable.
4. Ask questions of your health care provider and research library and/or reliable web resources for any further information you might need.
5. Take this form with you whenever you will be meeting with a new health provider.

More information about the Health History Summary

More information about the Health History Summary and testing its usefulness for teens with special health care needs and disabilities is described in the article “Promoting Successful Transition from Pediatric to Adult-Oriented Health Care” in the March 2004 edition of Exceptional Parent magazine.

Website Also, for instant pdf downloads of the “how-to” and form, visit these AHTP links:

Links <http://www.depts.washington.edu/healthtr/healthhistory/howto.doc>
<http://www.depts.washington.edu/healthtr/healthhistory/summary.doc>

AHTP Health History Summary Form

Health History Summary



As you make the transition from pediatric to adult health care, you will be assuming more responsibility for your health care. When you go to your new adult doctor (or other health care provider), you will be asked about major health events in your life. Have a parent help you fill out this form and take it with you when you go to your new adult care doctor (or other health care provider) and you will be prepared for the questions that you will be asked.

Describe yourself			
How would you describe your overall general health?			
Please circle one and add comments if you want to.			
<div style="display: flex; justify-content: space-around;"> Fair Good Excellent </div>			
What are your special health care needs?			
As a child and teenager, what were your major health problems?			
What medications are you currently taking?			
Medication	What is it taken for?	How Much? (Dose)	How Often? (Schedule)

AHTP
Health
History
Summary
(continued)

Allergies or adverse reactions to medications:			
Are there any medications that you have taken that have caused you problems?			
Medication		Reasons no longer taking medication	
Do you have food or other allergies? (include bee stings)			
Food or Substance		Reaction and Treatment	
Past Medical History			
Your Birth Weight		Were you born early? Y N	
		If so, how many weeks early?	
Did your mother have any problems with her pregnancy or delivery of you?			
Were you hospitalized at the time of your birth?		Y N	
		If yes, how many days?	
		Or weeks?	
What problems did you have at birth?			
List any serious illnesses you have had and injuries that included loss of consciousness.			
Please list hospitalizations and surgeries you have had.			
Date	Place	Hospitalization or Surgery	

AHTP
Health
History
Summary
(continued)

Personal Health History					
Have YOU ever had the following?					
Condition	Yes	Age	Condition	Y	Age
Anemia			Depression		
Asthma			Suicide Attempt		
Blood Transfusion			Conduct Disorder		
Cancer			Anxiety		
Constipation			Learning Disability		
Diabetes			Developmental Delay		
Ear Infection			Eating Disorder		
Eating Problems			Others not listed:		
Heart Disease					
Hepatitis					
Seizures (Epilepsy)					
Tuberculosis					
Attention Deficit Disorder (ADD)					
If the answer is yes to any of the above conditions, please use this space to make any additional comments about the conditions. For individuals with seizures, describe the seizures and include how often the seizures occur, how long they last, and when was your last one?					
What tests have previously been done for these conditions; what were the results; and where were they done? (MRI, CT, EKG, Genetic Testing, Blood Tests, Psychological Testing?)					
What treatments have been tried for these conditions and what was the most successful?					

AHTP
Health
History
Summary
(continued)

Are the conditions (please circle) :		The Same	Improving	Getting Worse
Resource Information				
School		Grade in school		
Do you have an Individualized Education Plan (IEP)?			Y N	
Do you have a 504 Plan?			Y N	
Name of contact person at school				
Contact Telephone		Contact Fax		
Do you use Vocational Rehabilitation (VR) services?			Y N	
Contact person at VR				
Recent Medical Records				
List any doctors or other health care providers who have the latest medical records about your health conditions.				
Name	Specialty	Address	Telephone	
Other Resources				
List any other person that has worked with you in regard to your health condition in the past 2 years (such as a physical therapist, pharmacist, medical supply house, caseworker, school nurse...).				
Name	What They Do	Address	Telephone	

AHTP
Health
History
Summary
(continued)

Your Immunization Dates (or attach a copy of your immunization record)					
DTP/DT	1.	2.	3.	4.	5.
TD	1.	2.	3.	4.	5.
OPV	1.	2.	3.	4.	5.
MMR	1.	2.			
HIB	1.	2.	3.	4.	
Hep B	1.	2.	3.	4.	
Varicella	1.	2.			
Family Health History					
Have any of your blood relatives had the following:					
Condition	Relation		Condition	Relation	
Anemia			ADD/ADHD		
Breast Cancer			Alcoholism		
Cancer (other)			Depression		
Diabetes			Drug Abuse		
Heart Attack			Learning Disability		
High Blood Pressure			Manic Depressive		
High Cholesterol			Suicide		
Seizures			Schizophrenia		
Sickle Cell Anemia			Other Conditions?		
Stroke					
Thyroid Problems					
Tuberculosis					
Comments:					
Insurance Coverage Information					
Insurance			Policy Number		Telephone
Do you receive social security income (SSI)?					Y N
Do you receive medical benefits through the SSI program?					Y N
Emergency Contacts:					

[illegible]



AHTP Transition Timeline

Achieving Health Care Independence: A Transition Timeline

Children and families experience many transitions, large and small, over the years. Three predictable transitions occur: when children reach school age, when they approach adolescence, and when they move from adolescence to adulthood. Other transitions include moving into new programs, working with new agencies and care providers, and making new friends. Transitions involve changes: adding new expectations, responsibilities or resources, and letting go of others.

As a parent of a child with special health care needs you may be caught up in day to day survival. You may ask, "How can I think about tomorrow when I'm just trying to make it through today?" But when those moments come when you can catch your breath it may be helpful to be aware of those transitions and allow yourself to think about the future.

The Transition Timeline for Children and Adolescents with Special Health Care Needs may help you think about the future. We hope it will give you ideas to help your child achieve independence in his or her own health care, and in other areas of life as he or she grows.

Ages
12 to 18

Transition Timeline for Children & Adolescents with Special Health Care Needs

12 to 18 Years Old (or according to your child's developmental ability)

- Continue to allow your teen to help with family chores.
- Continue teaching your teen normal self-help skills as well as skills related to his or her special health care need.
- Continue to encourage hobbies and leisure activities.
- Assess your teen's perception and basic knowledge of his or her special health care need, and fill in gaps in his or her understanding.
- Begin helping your teen keep a record of his/her medical history, including conditions, operations, treatments (dates, doctors, recommendations) and Individualized Education Program (IEP) if on an IEP.
- If on an IEP, encourage teen to participate in IEP meeting.
- Begin helping your teen take responsibility for making and keeping his or her own medical appointments and ordering supplies.
- Begin exploring health care financing for your soon-to-be young adult.
- Discuss sexuality with your teen.
- Help your teen identify and build on his or her strengths.
- If your teen is interested, explore support groups.
- Begin to talk about and explore career interests with your teen.
- Help your teen find work and volunteer activities.
- Help your teen identify and be involved with adult or older teen role models.
- With your teen, encourage age-appropriate care from his/her family practitioner or pediatrician.
- With your teen, begin to identify with whom they will eventually be receiving their health care as an adult.

AHTP Transition Timeline (continued)

Transition Timeline (continued)	
18 up to 22 Years Old (or according to your child's developmental ability)	
<ul style="list-style-type: none"> • You may want to encourage your young adult with an IEP, to stay in a school program up to age 22. • Continue to encourage your young adult with an IEP, to participate in IEP meetings. • Continue transition planning with your young adult and IEP team, including employment and adult life activities. • Act as a resource and support to your young adult. • Encourage your young adult to participate in support groups and/or organizations relevant to his or her special health care need. • Finalize health care financing with your young adult. • With your young adult, finalize age-appropriate medical care from his/her family practitioner or transfer to an adult provider. 	
Transition to Adulthood: Services or Contacts to Consider	
By age 14	
<ul style="list-style-type: none"> • Transition Plan from School to Post-School options begins for teens on IEPs. They must be invited to participate in their IEP meeting. 	
By age 17	
<ul style="list-style-type: none"> • Begin exploring health care financing for young adults. • Notify the California Department of Rehabilitation (DR) for teens with and without IEPs by Autumn of the year before they graduate. • If appropriate, begin guardianship procedures two months before the teen turns 18. Guardianship may be full or limited. • Notify student of rights that will transfer to him/her on reaching the age of majority at least one year before the student reaches the age of majority (age 18 in California). 	
By age 18	
<ul style="list-style-type: none"> • Check eligibility for SSI the month the teen turns 18. • Investigate SSI work incentives. • Contact campus Disabled Student Programs & Services (DSPS) to request accommodations for youth attending college. 	

Resource Guide Note:

In your Alameda County Medical Home Project Resource Guide, we have included only the "Transition-to-Adult" portion of the AHTP Transition Timeline. The entire timeline, beginning from birth, can be found at:
<http://depts.washington.edu/healthtr/Timeline/timeline.htm>

AHTP Taking Control of Your Own Health Care: Teens & Young Adults Information for Teens And Young Adults



You're taking control of your own health care. It's a big step! Teenagers and young adults need to learn how to make appointments, talk to doctors, and get the information they need to make good decisions. It can seem overwhelming at first, but lots of other people have the same questions you do.

Questions Many Teens Ask about their Health Care

1. How can I select the best health care provider for me?

- If you are switching to an adult practitioner, ask for suggestions from your local hospital's referral service, the national organization of your chronic illness or disability, your present pediatric doctor and other adults with your disability or illness. Remember, you can interview a doctor before you decide to choose him or her as your doctor.
- If you are staying with your family care practitioner, tell him or her that you are working toward taking responsibility for your own health care.

2. How should I prepare for my health care appointment?

- If it's your first appointment, make sure you schedule enough time for it. The staff person scheduling your appointment should be able to help you estimate the time you'll need.
- Write down your concerns and questions ahead of time.
- Write a short summary of your condition, including past and present treatments and medications, to share with your health care provider.
- Bring any equipment you use with you.
- You also may want to bring paper and pencil to take notes to read later, or you may bring a tape recorder to record your visit. (Request the provider's permission before tape recording.)

3. How do I work with health care professionals to get the most out of my medical plan?

- Take responsibility for becoming part of the team that determines your care. Ask questions!
- Be straightforward and thoughtful when you talk with health care professionals.
- Be considerate, and have a positive attitude.

4. How can I gain some control over my health care, and make my own decisions?

Be well informed about yourself:

- Read about your disability or chronic illness.
- Ask your health care professional what you can expect of your body, now and in the future.
- Talk to other people who have the same disability or illness.

5. How can I get the information and help I need with my health concerns?

Other people have similar concerns, so you're not alone. There are lots of resources for you, but to find them you need to be persistent and not give up:

- Check with your pediatrician or family practitioner, your school or public library, organizations that represent people with your disability or chronic illness, newsletters, and state and national government offices for persons with disabilities.

6. How do I deal with my feelings about what is happening with my body?

AHTP
Teens
& Young
Adults
(continued)

Again, you're not alone. Lots of people have had similar feelings and concerns:

- It helps to talk with other teens or adults who share your disability or illness. It's also a good idea to attend peer support groups and organizations.
- Psychologists, nurses, social workers, school counselors, ministers, rabbis, and priests can also offer support and guidance.
- You can also read books by people who have learned to deal with disability or chronic illness, and magazines written especially for people with disabilities or chronic illness.



AHTP
Autonomy
Checklists

Take Control of your Health Care in 10 Easy Steps	
1	Make sure you have a good, basic understanding of your disability.
2	Keep a record of your medical history: conditions, dates of operations, treatments, names of doctors, their recommendations, etc. If your parents have already started a record for you, you can add to it.
3	Make your own medical appointments and order your own supplies.
4	Practice anticipatory appointment setting: If you start to feel sick, make an appointment with your doctor for a few days later. That way, if you do become sick, you won't have to wait for your appointment. But if you get better before your scheduled appointment, be sure to cancel the appointment right away!
5	Insist that your health care team members talk to you about your results. Ask the team to communicate among themselves so they don't give you mixed or confusing information.
6	If you're female, find a physician who understands the needs and concerns of women with your disability.
7	As your body changes, make changes in your diet. Keep an appropriate weight for your mobility and general health.
8	Develop an exercise pattern for yourself.
9	Get involved in sports. They'll help you stay physically fit, and give you a chance to socialize with new friends.
10	Take good care of your mental health: Take time for hobbies, movies, shopping, and other things you enjoy. Ask your health professionals for more information on topics related to mental health, such as self-esteem, confidence, depression, and sexuality.

**Make Connections with People in Your Community and
Become More Independent**

- Serve as a resource person for clinics that serve other people with your disability.
- Participate in peer support groups.
- Act as a role model for younger people with your illness or disability.
- Learn about the people in your community who can help you with psychological problems.
- Join associations that represent your disability or chronic illness.
- If you have questions about sexuality, ask someone you know and feel comfortable with—perhaps a teacher, counselor, health professional or one of your parents.
- Get involved in a team sport. You'll make new friends, and the exercise will be good for you!

AHTP Autonomy Checklists

Autonomy Checklists
(continued)

Use these checklists as an ongoing measurement of independent skills achieved.

Skills at Home Checklist				
Kitchen	Can Do Already	Need Practice	Plan to Start	Achieved
Operate appliances (cook top, oven, microwave, toaster, dishwasher)				
Use common kitchen tools (can opener, bottle opener, knife, measuring cups and spoons, grater, timer, egg beater...)				
Help plan and prepare meals				
Follow a recipe				
Put away the leftovers				
Set the table				
Do the dishes				
Familiarity with contents of packaged foods				
Laundry				
Put dirty clothes in hamper				
Sort clothes				
Use washer and dryer				
Iron				
Hand wash				
Fold clothes				
Put clothes away				
With the Family				
Watch TV news and discuss together				
Help take care of siblings				
Participate in family decisions				
Plan family outing				
Take care of pets				
Housekeeping				
Clean room				
Make the bed/change the bed				
Choose decorations for room				
Minor repairs (change light bulbs, repair/assemble toys)				
Take out the trash				
Basic sewing/mending skills				

AHTP
Autonomy
Checklists
(continued)

Skills at Home Checklist (continued)				
Gardening	Can Do Already	Need Practice	Plan to Start	Achieved
Plant a garden				
Mow/water the lawn				
Weed the garden				
Learn appropriate use of garden tools				
Emergencies				
Plan fire exits and emergency procedures				
Know where candles and flashlights are				
Use a fire extinguisher				
Know how to turn water off				
Know emergency telephone numbers				
Know where extra house key is located				
Unclog the sink or toilet				
Personal Skills				
Use the phone				
Have a house key				
Budget allowance				
Go shopping				
Have privacy in the bathroom				
Manage personal grooming (shampoo, bath, shower)				
Get a haircut				
Choose appropriate clothes to wear				

AHTP
Autonomy
Checklists
(continued)

Health Care Checklist				
Health Care Skills	Can Do Already	Need Practice	Plan to Start	Achieved
Understand health status				
Be aware of existence of medical records, diagnosis information, etc.				
Prepare questions for doctors, nurses, therapists				
Respond to questions from doctors, nurses, therapists				
Know medications and what they're for				
Get a prescription refilled				
Keep a calendar of doctor, dentist appointments				
Know height, weight, birthdate				
Learn how to read a thermometer				
Know health emergency telephone numbers				
Know medical coverage numbers				
Obtain sex education materials/birth control if indicated				
Discuss role in health maintenance				
Have genetic counseling if appropriate				
Discuss drugs and alcohol with family				
Make contact with appropriate community advocacy organization				
Take care of own menstrual needs and keep a record of monthly periods				

AHTP
Autonomy
Checklists
(continued)

Community Skills Checklist				
Community Skills	Can Do Already	Need Practice	Plan to Start	Achieved
Get around the city (pedestrian skills, asking directions)				
Use public transportation (taxi, bus, etc.)				
Locate bathroom in unfamiliar building (i.e. know how to ask)				
Know about neighborhood stores/services				
Use a pay phone				
Use a phone book				
Open a bank account				
Get a library card				
Get a picture ID				
Get a Social Security Card				
Use Post Office				
Volunteer for community services				

Leisure Time Skills Checklist				
Leisure Time Skills	Can Do Already	Need Practice	Plan to Start	Achieved
Help plan a party				
Invite a friend over				
Subscribe to a magazine				
Read a book				
Plan a TV viewing schedule				
Go for a walk				
Join the Scouts, YMCA/YWCA, 4-H Club				
Go to a recreation center				
Go to camp				
Attend school functions (plays, dances, concerts, sports)				
Go to Church				
Keep a calendar of events				
Participate in a sport				

Skills for the Future Checklist				
Education	Can Do Already	Need Practice	Plan to Start	Achieved
Meet with school Guidance Counselor				
Check future educational options				
Vocational/Technical Options				
Contact school Guidance or DVR Counselor				
Check on local workshops and job opportunities				
Find out about apprentice programs				
Get information from community colleges				
Learn how to apply for a job				
Living Arrangements				
Be aware of federal housing regulations for the disabled				
Explore group homes and tenant support apartment living programs				
Find out about financial assistance programs				
Learn how to manage money and budget household expenses				
Understand leases				
Know the responsibilities of a tenant and landlord				
Know how to fill out an application				
Check for wheelchair accessibility if needed				
Look into transportation				
Know about services: electricity, phone, water				

Web site <http://depts.washington.edu/healthtr/Checklists/intro.htm>
 Source Autonomy Checklists developed by the Youth in Transition Project (1984-1987) University of Washington Division of Adolescent Medicine and based on a Model developed by the Children's Rehabilitation Center at the University of Virginia.

Department of Rehabilitation (DOR)



Department of Rehabilitation (DOR) offers a number of services for youth and adults with disabilities. The goal of rehabilitation services is to help individuals to get a job, live independently and become self-sufficient. Once eligibility has been determined, an Individualized Plan for Employment (IPE) is then developed. The IPE contains the consumer's employment goal, activities or objectives to be implemented or undertaken to achieve the goal and needed rehabilitation services.

Services What services are available?

There are many services available including:

- ❑ Vocational training
- ❑ Purchase of work-related equipment and supplies (work clothes, safety equipment, interpreters, etc.)
- ❑ Job search
- ❑ Development and placement services that include job coaches and on the job training

Joint Programs of the Departments of Rehabilitation and Education/WorkAbility

The Departments of Rehabilitation and Education have joint programs available for students with disabilities that enable them to acquire job skills and on-the-job work experience while they are still in school. For example, the DOR may provide a job coach to assist a young adult to learn a job at no expense to the employer. The Department of Rehabilitation can provide a job coach 100% of on-the-job time for 1 to 2 months and, in some instances, for up to 4 months. [See WorkAbility information in this section]

Where are services provided?

DOR offices are located in local communities throughout California.

Eligibility Who is eligible?

Youth (16 years and older) who have disabilities are eligible. Determination of disability status will require documentation that includes medical and school records.

Enrollment How do you enroll?

- ❑ Applicant can go directly to the local Department of Rehabilitation office, fill out the application by mail, or fax a request.
- ❑ The individual is notified of eligibility within 60 days from the date of application.
- ❑ The individual will need to present medical and school record documentation of his/her disability.

Waiting List DOR institutes an "Order of Selection" if there are more individuals than agency resources. Individuals are placed on a waiting list using a number of criteria that determines their placement on the list.

Contact
Information (415) 904-7100
415) 904-7138 TTY

CA Department of Rehabilitation
San Francisco Branch Office
301 Howard Street, Suite 700
San Francisco, CA 94105

Web site

<http://www.rehab.ca.gov>

Disabled Student Programs and Services (DSPS)



Disabled Students Programs and Services (DSPS) are available for students with special health care needs (SHCN) who choose to attend a college or university. It is essential for the student to contact the DSPS office upon their admission to the college. The DSPS office can offer the student a number of services that will enable him or her to get his or her accommodation needs met and become a member of the campus community. Support services are available for all students with a verified temporary or permanent disability who are regularly enrolled.

Services What services are provided?

Support services may include but are not limited to:

- ❑ Registration assistance
- ❑ Classroom accommodations
- ❑ Mobility services
- ❑ Services for the deaf
- ❑ Large type print access for the visually impaired
- ❑ Learning disability services
- ❑ Priority scheduling
- ❑ Note taking
- ❑ Alternate course assignments

Providers Where are services provided?

DSPS are located on every private and public community college, 4-year college and university campus.

Eligibility Who is eligible?

Students may be eligible for one or more services, depending on the specific nature of their disability. Disability verification must be provided when registering with DSPS. The criteria used for verification of diagnosis will vary, dependent upon the diagnosis. Verification can be facilitated if the student has copies of his/her medical records documenting their diagnosis. Students will be given a “grace” period before the deadline for submitting disability verification.

Enrollment How do you enroll?

Ideally, consumers refer themselves. Professionals working with youth during their transition process can provide the student with the needed information. Access to campus programs can also be facilitated through the School-to-Career programs within the school districts.

Call your... Local Community College or Post-secondary Institution’s
Disabled Student Programs and Services (DSPS) office

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Regional Occupational Centers and Programs (ROCP)



Regional Occupational Centers/Programs (ROCP) serve more than 400,000 students in California. ROCPs offer over 100 technical education courses in healthcare, business, culinary arts, agriculture, information technology, consumer and human services, construction, and auto repair.

Services What services are provided?

These programs offer high school students and adult learners career preparation courses and job training experiences, such as:

- Career technical preparation courses in conjunction with Tech Prep and High Tech programs
- College-level academic courses that can be accepted by community colleges and universities
- Workforce preparation services in conjunction with the Employment Development Department (EDD), Workforce Investment Boards (WIB), Department of Rehabilitation (DOR), and Department of Social Services (DSS)
- Career planning services such interviewing skills, resume writing and development of a career portfolio

Providers Where are services provided?

Seventy-two ROCPs are located throughout California. On-the-job training experiences are provided directly in various worksites such as hospitals, department stores, and restaurants. Classroom instruction is offered on the ROCP campuses.

Eligibility Who is eligible?

Youth and adults, with or without disabilities (who are at least 16 years old) are eligible.

Enrollment How do you enroll?

Students can contact their high school Guidance Department/ROP counselor to register for classes. Students in private schools can contact the ROCP directly. Students can enroll in ROCPs that are not in their school districts. Post-secondary students with disabilities must make appointments with the ROCP Disabled Student Programs and Services (DSPS) office. Students must have verification of their disabilities in order to receive the accommodations needed to participate in ROCP courses.

Contact Information	(415) 241-6000	San Francisco Unified School District
	(415) 241-6012 FAX	555 Franklin Street
		San Francisco, CA 94020

Web site	http://www.sfusd.edu
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WorkAbility Programs

WorkAbility programs comprise a number of Joint Programs administered by the Department of Rehabilitation (DOR) in partnership with school districts, community colleges or universities (depending on the student's level of education) specifically for students with disabilities. The goals of these programs are to provide students with job development and placement services for work and career opportunities. [see Department of Rehabilitation Joint Program information in this section]

WorkAbility I

Promotes independent living and provides comprehensive pre-employment worksite training, employment and follow-up services for transitioning youth, enabling them to obtain marketable job skills while completing their education.

WorkAbility II

Assists adult consumers with disabilities who meet the DOR eligibility requirements through a variety of DOR individualized services.

WorkAbility III

Serves people with disabilities who are both community college students and DOR clients in need of employment. These programs offer direct job placement and transition assistance into employment and support services.

WorkAbility IV

These are cooperative interagency programs between the DOR, California State Universities (CSU) and University of California (UC) campuses. These programs assist students with disabilities who are both DOR clients and CSU or UC students transitioning from school to careers.

What services are available?

There are many services available including:

- Vocational and basic skills assessment
- Job counseling and guidance
- Development and placement services that include job coaches and on-the-job training.

Where are services provided?

Depending on the WorkAbility program, services are available at local school districts, community colleges, California State Universities and University of California campuses.

Who is eligible?

Students with documented disabilities (as determined by the DOR eligibility worker) enrolled in school districts, community colleges, and California State Universities and Universities of California campuses.

Enrollment How do you enroll?
The student may go directly to their local school district to find out if there is a WorkAbility program. College students can obtain information about WorkAbility programs from the campus Disabled Student Programs and Services (DSPS) Office or his/her local Department of Rehabilitation office.

Contact Information (415) 904-7100 CA Department of Rehabilitation
San Francisco Branch Office
415) 904-7138 TTY 301 Howard Street, Suite 700
San Francisco, CA 94105

Web site <http://www.rehab.ca.gov>

For Educational Contacts for Joint Programs/Workability:

Call your... Child's Home School
Call your... Child's Local School District's Dept. of Special Education

Call your... Special Education Local Planning Area (SELPA) Office:
(415)379-7697 SELPA - San Francisco

Call your... Local Community College or Post-secondary Institution's
Disabled Student Programs and Services (DSPS) office

Web site Disability Benefits 101
For other information about working with a disability in
California, including benefits planners and calculators.
<http://www.disabilitybenefits101.org>



- Q San Francisco Community Resources - Wall Laminate (sample)
- Q San Francisco Resource Referrals - Rx-pad (sample)
- Q CCS Application for Services
- Q CCS Referral Form
- Q CCS Transitioning to Adulthood
- Q PRRS Referral Form (English, Spanish & Chinese)
- Q Special Education Pediatrician/Parent Referral Letters to School District:
 - Assessment Referral/Request - General
- Q Modified Checklist for Autism in Toddlers (M-CHAT)
 - *M-CHAT Information / English / English Scoring / Spanish / Spanish Scoring
- Q Golden Gate Regional Center (GGRC)
- Q GGRC Early Start (0-3) Referral Form
- Q GGRC Parent Intake Form

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San Francisco County Community Resources



Every child
deserves a
medical home.

Bay Area Legal Aid	415 982-1300
Legal services for low income individuals.	
California Children's Services (CCS)	415 575-5700
Specialized medical care for children with eligible medical conditions (ages 0 up to 21 years).	
Child Health & Disability Prevention (CHDP)	415 575-5712
Free health checkups and immunizations for low income children (ages 0 up to 19, or 21 with Medi-Cal).	
Community Behavioral Health Systems (CBHS)	
Assessment, counseling, referral, and other services for mental health and substance problems.	
Health	Mental 415 255-3400
	415 255-3500
	Treatment Access Programs 800 750-2727
Dental Care (Denti-Cal)	800 322-6384
Referrals to dental services for Medi-Cal eligible individuals (all ages).	800-880-5305
Comprehensive Child Crisis Services	415 970-3800
Parent Support Line, Counseling, 24-hour-support, other mental health services.	
Support for Families of Children with Disabilities	415 282-7494
Free information, referral services, advocacy, and parent-to-parent support for children with disabilities or special health care needs (ages 0 up to 22 years).	
	Warmline 415-920-5040
CalFresh	415 558-1158
Vouchers for groceries.	
Golden Gate Regional Center	415 546-9222
Services and case management for individuals with developmental disabilities (all ages).	
San Francisco Department Human Services	415 557-5000
Services for families in the areas of financial, housing, and child care referral assistance.	
Medi-Cal/Healthy Families Programs	866-848-9166
Free and low cost health insurance with eligibility based on family income.	
Healthy Kids and Young Adults	415-777-9992
Health Connections (Medi-Cal)	415-863-9892
San Francisco County Special Education	415-355-7735
Provides services through local public schools for students with special needs (ages 3 up to 22 years). Includes SELPA and Head Start programs.	
	Enrollment Child Development Programs 415-750-8507
Supplemental Security Income (SSI)	800 772-1213
Cash assistance and Medi-Cal to low income disabled individuals (all ages).	
Women, Infants, and Children (WIC)	
Nutrition and breastfeeding counseling, food vouchers, and breast pump loans to low income pregnant or nursing women, infants, and children (ages 0-5).	
	San Francisco General Hospital 415 206-5494
	Silver Ave Family Health Center 415 657-1724
	Chinatown Public Health Center 415 364-7654
	Ocean-Park Health Center 415 682-1928
	Southeast Health Center 415 671-7059



**Lucile Packard
Children's Hospital
at Stanford**



**SUPPORT FOR FAMILIES
OF CHILDREN WITH DISABILITIES**

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San Francisco County Resource Referrals

Every child deserves a medical home

Referral Date: _____

Patient: _____

Provider: _____

HEALTH SERVICES

<input type="checkbox"/> CCS	415 575-5700
<input type="checkbox"/> Denti-Cal	800 322-6384
<input type="checkbox"/> Healthy Families	888 747-1222
<input type="checkbox"/> Healthy Kids	415 777-9992
<input type="checkbox"/> Medi-Cal	415 863-9892
Enrollment	888 558-5858
<input type="checkbox"/> Mental Health	415 255-3737
Alcohol and Drug	800 750-2727

EDUCATIONAL DEVELOPMENTAL SERVICES

<input type="checkbox"/> Head Start	415 405-0500
<input type="checkbox"/> Regional Center Golden Gate	415 546-9222
<input type="checkbox"/> Special Education- SELPAs	415 355-7735
<input type="checkbox"/> Vocational Rehab	415 904-7100

Additional Comments:

FAMILY SUPPORT AND ADVOCACY

<input type="checkbox"/> Child Care	415 276-2900
<input type="checkbox"/> Family Crisis	415 970-3800
<input type="checkbox"/> SFCD (FRC)	415 282-7494
Warmline	415 920-5040
<input type="checkbox"/> Regional Center	415 546-9222

FAMILY ASSISTANCE PROGRAMS

<input type="checkbox"/> Bay Area Legal Aid	415 982-1300
<input type="checkbox"/> Domestic Violence	415 864-4722
<input type="checkbox"/> Family Crisis	415 970-3800
<input type="checkbox"/> CalFresh	415 558-1158
<input type="checkbox"/> Human Services	415 557-5000
<input type="checkbox"/> SSI	800 772-1213
<input type="checkbox"/> WIC	415 575-5788
Chinatown HC	415 364-7654
Ocean-Park	415 682-1928
SFGH	415 206-5494
Silver Ave FHC	415 715-0324
Southeast HC	415 671-7059

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APPLICATION TO DETERMINE CCS PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term "applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. For instructions on completing this form, please see page 4. Please type or print clearly.

A. Applicant Information

1. Name of applicant (last) (first) (middle)			Name on birth certificate (if different)		Any other name the applicant is known by	
2. Date of birth (month, day, year)			3. Place of birth—county and state		Country, if born outside the U.S.	
4. Applicant's residence address (number, street) (do not use a P.O. box)			City		County	ZIP code
5. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			6. Race/ Ethnicity		7. Social security number (optional)	
8. What is the applicant's suspected eligible CCS condition or disability?						
9. Name of applicant's physician					10. Physician's phone number ()	

B. Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. Name(s) of parent or legal guardian			12. Mother's first name (if not identified in 11) Maiden name			
13. Residence address (number, street) (do not use a P.O. box)			City		County	ZIP code
14. Mailing address (if different from 13)			City		ZIP code	
15. Day phone number ()		16. Evening phone number ()		17. Message phone number ()		18. What language do you speak at home?

C. Health Insurance Information

19. Does the applicant have Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what is the applicant's Medi-Cal number?		Is there a share-of-cost? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what amount do you pay per month? \$	
20. Is the applicant enrolled in the Healthy Families program? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what is the name of the plan?					
21. Does the applicant have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what is the name of the insurance plan or company?					
Type of insurance plan or company <input type="checkbox"/> Preferred Provider (PPO) <input type="checkbox"/> Health Maintenance Organization (HMO) <input type="checkbox"/> Other: _____							
22. Does the applicant have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				23. Does the applicant have vision insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			

D. Certification (Initial and sign below. Your signature authorizes the CCS program to proceed with this application.)

___ I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of the applicant by the CCS program.

___ I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

___ I certify that I have read and understand the information or have had it read to me.

___ I also certify that the information I have given on this form is true and correct.

Signature of person completing the application		Relationship to the applicant	Date
Signature of witness (only if the person signed with a mark)		Date	

Mail this form to your county CCS office.

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information						
1. Date of request		2. Provider name			3. Medi-Cal provider number	
4. Address (number, street)				City	State	ZIP code
5. Contact person		6. Contact telephone number ()		7. Contact fax number ()		
Client Information						
8. Client name—last		first		middle		
9. Alias (AKA)			10. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		11. Date of birth (mm/dd/yy)	
12. CCS/GHPP case number		13. Contact phone number ()		14. Medical record number (hospital or office)		
15. Residence address (number, street) (DO NOT USE P.O. BOX)				City	State	ZIP code
16. Mailing address (if different) (number, street, P.O. box number)				City	State	ZIP code
17. County of residence		18. Language spoken		19. Name of parent/legal guardian		
20. Mother's first name		21. Primary care physician (if known)		22. Primary care physician telephone number ()		
Insurance Information						
23.a. Enrolled in Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No		23.b. If yes, client index number (CIN)		23.c. Client's Medi-Cal number		
24. Enrolled in Healthy Families <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of plan				
25. Enrolled in commercial insurance plan <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, type of commercial insurance plan <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other		Name of plan		
Diagnosis						
26. Diagnosis (DX)/ICD-9: _____ DX/ICD-9: _____ DX/ICD-9: _____						
Requested Services						
27.* CPT-4/ HCPCS Code/NDC	28. Specific Description of Service/Procedure		29. From (mm/dd/yy)	To (mm/dd/yy)	30. Frequency/ Duration	31. Units
						32. Quantity (Pharmacy Only)
* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.						
33. Other documentation attached <input type="checkbox"/> Yes		34. Enter facility name (where requested services will be performed, if other than office).				
Inpatient Hospital Services						
35. Begin date		36. End date		37. Number of days		
Additional Services Requested from Other Health Care Providers						
38. Provider's name		Medi-Cal provider number		Telephone number ()		Contact person
Address (number, street)		City		State		ZIP code
Description of services		Procedure code		Units		Quantity
Additional information						
39. Provider's name		Medi-Cal provider number		Telephone number ()		Contact person
Address (number, street)		City		State		ZIP code
Description of services		Procedure code		Units		Quantity
Additional information						
40. Signature of physician/provider or authorized designee					41. Date	

CALIFORNIA CHILDREN'S SERVICES
SAN FRANCISCO

***"TRANSITIONING TO
ADULTHOOD"***



At age 21 your child will no longer be eligible for California Children's Services (CCS). CCS offers transition planning for healthcare services. Transition planning means preparing for the movement of adolescents and young adults from child-centered to adult-oriented services and systems. It can include:

- Obtaining information on changes in services and legal status which will occur as a child reaches adulthood.
- Identifying healthcare needs and adult providers.
- Understanding the available supports and services.
- Identifying steps toward independence for individuals and their families.
- Coordinating with other agencies that provide education, employment, recreation and independent or supported living.

If you would like help with transition planning, please contact your CCS Case Manager at 575-5700 or MTU therapist at 759-2919.

CCS SAN FRANCISCO HEALTH CARE SKILLS CHECK LIST

This health care list can be used as a guide to develop independence in managing one's own health.

Topics	Performs Independently	Performs Partially	Needs Assistance	Comments
Describes medical condition				
Understands how condition affects daily life				
Maintains personal medical file and diagnosis information				
Prepares and asks questions for doctors, nurses, therapists, etc.				
Knows medications and what they are for, or carries information				
Is responsible for taking medication				
Is responsible for doing own treatments				
Is responsible for managing own diet				
Gets prescriptions filled/refilled				
Calls to schedule own medical/dental appointments				
Keeps a calendar of medical appointments				
Knows how to arrange transportation to appointments				
Knows how to use and read a thermometer				
Knows "danger signs" of condition and when to seek care				
Knows health emergency phone numbers, or carries info in wallet				
Knows medical coverage numbers, or carries info in wallet				
Knows about medical insurance coverage and carries information				
Understands general health care needs and prevention				
Obtains sex education material/birth control/family planning information as needed				
Has considered genetic counseling, if appropriate				
Knows about how drugs/alcohol affect illness/disability				
Makes contact with appropriate community resources				
Takes care of own menstrual needs and keeps a record of monthly periods				
Has considered the need for a health advocate				
Has identified a physician for adult care				
Knows how to hire and manage a personal care attendant				
Maintains supplies and equipment (medical, DME, etc.)				

Adapted from the Adult Metabolic Transition Project, University of Washington

SF-TR-06 (9/19/07)

CCS SAN FRANCISCO

TRANSITION GUIDELINE

AGE 14-16	N/A	Addressed	Notes
• Discuss client's understanding and ability to explain their medical condition			
• Therapists incorporate transition goals into their treatment plan/goals			
• Evaluate and plan for recreational needs of the client			
• Encourage discussion of medical treatment plan with care providers and family			
• Identify need for community resources or social work			
• Increase client/guardian responsibility for equipment, appointment scheduling, communication with providers, medication, and supply ordering			
• Assess community access and transportation needs			
• Encourage family to keep medical records updated and information available for emergencies (<i>offer forms if needed</i>)			
AGE 17-18			
• Review IEP transition plan			
• Review plans for insurance coverage			
• Discuss plans for the living situation			
• Refer to Vocational Rehabilitation			
• Refer to college disability programs if appropriate			
• Notify client of rights at age of majority – provide "Rights at Age of Majority (18)" handout if appropriate			
• Consider guardianship/conservatorship issues			
• Discuss plans to transition to adult care providers			
• Review if client should apply for SSI			
• Client can report on their own behalf in the MTC and sign their own paperwork (age 18)			
AGE 19-20			
• Discuss plans for ongoing insurance coverage			
• Review medication concerns/issues			
• Discuss plans to transition to an adult care provider			
• Review plans for the clients living situation			
• Review insurance coverage			
• Review plans to transition to an adult care provider			
• Review plans for living situation			
• Consider referral to GHPP			
• Finalize equipment / supply orders			
• Finalize referrals to community resources			
• Begin to complete Exit Summary form			
EXIT			
• Finalize Exit Summary form and provide copy to client			
• Provide copies of medical records			
• Provide additional resources as needed			

CCS SAN FRANCISCO RIGHTS AT AGE OF MAJORITY (18)

1. To give or withhold medical consent
2. To create advance directives (DNR orders)
3. To apply for SSI as an independent adult (living w/ parents or independently)
4. To apply for Medi-Cal independently (only if living independently)
5. To fix place of residence (sign lease, etc.)
6. To vote
7. To register for the draft
8. To make contracts
9. To purchase health insurance independently, but varies with some companies
(Kaiser is age 19)

RESOURCES:

Legal Services for Children (415) 863-3762 www.lsc-sf.org
(for issues of guardianship/ custody or emancipation under age 18 only)

Bar Association of San Francisco - Lawyer Referral Service (415) 989-1616
(for conservatorships at age 18; ½ hour consultation is \$25)

Department of Rehabilitation (415) 904-7100
(vocational assessments, training) www.rehab.cahwnet.gov/eps/handbook.htm

Social Security Administration (SSI) 1-800-772-1213

Medi-Cal San Francisco Office (415) 863-9892

City College of San Francisco (415) 239-3000
John Adams campus for GED (415) 561-1900

UC Berkeley (Office of Disabled Students) (510) 642-0518

Bravekids.org (web site for kids with chronic or life-threatening illness or disability)

San Francisco Department of Public Health www.dph.sf.ca.us

California Department of Health Services www.dhs.cahwnet.gov

San Francisco Medical Web www.sanfranciscomedicalweb.com
(source for SF Bay Area health care information)

CCS SAN FRANCISCO

HEALTH CARE TOPICS

Transition time is an opportunity to work on becoming more independent. Developing health care skills can be challenging for both the individual and the family.

Independence will be defined differently for everyone, but most importantly, every individual will have some personal goals that they can work on to become more independent. Below are some topics that can be discussed to make the transition process from childhood to adulthood smoother.

- ❖ Develop an understanding of your **medical condition** so that you are able to describe or carry information that can clearly convey medical needs.
- ❖ Maintain a **personal medical file** including medical history and diagnosis information.
- ❖ **Prepare and ask questions** for doctors, nurses, nutritionists, therapists, social worker, etc. or have identified assistance with this.
- ❖ Have a goal or a plan for **medication management**. Know what they are for, learn to be responsible for taking medication, get prescriptions filled/refilled, or carry instructions for them.
- ❖ Maintain **supplies and equipment** including vendor names, numbers for re-orders and repairs or have a plan for this.
- ❖ **Manage diet** including understanding its impact on medical condition and be able to communicate the concerns or carry relevant information.
- ❖ Know **health emergency** telephone numbers or carry the information with you.
- ❖ Know how to arrange **transportation** to medical appointments including relevant mobility issues or have a plan to address this.
- ❖ Make **medical appointments** including follow-up and ensure that appointments are kept or have a plan in place.
- ❖ Know about **medical insurance** including policyholder, identification numbers, what services are covered and annual renewal dates or have a plan for assistance with this.
- ❖ Make contact with appropriate **community resources and organizations** or have a plan on how to do this, if needed.
- ❖ Understand **general health care** needs and prevention or have a plan to address this.

CCS SAN FRANCISCO

HEALTH COVERAGE INFORMATION

Full-Scope Medi-Cal (Ages 0-21)

Covers clients up to age 21 who are below 200% FPL, but can vary depending on age; to be eligible for Medi-Cal after age 21, client must be living independently.

SF Medi-Cal Office: 1440 Harrison St (@ 10th St), 863-9892

Medi-Cal Deeming

Covers Regional Center clients up to age 18, where a family's income is waived. Institutional deeming is a Federal Medicaid Waiver Program that covers disabled children as an alternative to institutionalization.

Golden Gate Regional Center: 375 Stevenson St, 6th Fl, 546-9222

SSI Medi-Cal

<http://www.socialsecurity.gov/ssi/index.htm>

Covers clients who are certified as disabled, blind or aged. Applying before age 18 makes it more likely that a client will have continued eligibility as an adult. If already receiving SSI before age 18, the client must re-apply for continued coverage by visiting one of the local district offices:

- Chinatown: 560 Kearny St (@ Sacramento St), 705-1067
- Civic Center: 939 Market St (btwn 5th & 6th Sts), 744-5730
- Mission: 1098 Valencia St (@ 22nd St), 556-4043
- Parkside: 1569 Sloat Blvd, Ste 300 (@ Clearfield/34th Ave), 556-4078
- Western Addition: 1405 Fillmore St, 556-9325

Healthy Families (Ages 0-18)

<http://www.healthyfamilies.ca.gov/English/joining.html>

Covers clients until their 19th birthday who are between 200%-250% of FPL.

State Healthy Families Ph#: 866-848-9166

Healthy Kids (Ages 0-18)

http://www.sfhp.org/visitors/programs/healthy_kids_young_adults/

Administered by San Francisco Health Plan (SFHP), covers clients until their 19th birthday who are between 250%-300% of FPL, including clients who are undocumented.

SFHP: 201 3rd St, 7th Fl, 888-558-5858

Healthy San Francisco & Sliding Scale (Ages 18-64)

<http://www.healthysanfrancisco.org/>

Health services at SFGH and CHN Health Centers for clients who are uninsured and may not be eligible for other public programs.

Healthy SF Inquiry Call Center: 615-4100 (M-F 8:30-5:30) or 311 (within City of SF anytime)

CCS SAN FRANCISCO

MEDICAL HISTORY/EMERGENCY WORKSHEET

Client Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Weight: _____ Height: _____ Date checked: _____

Language spoken at home: _____ Known communication limitations: _____

Client's usual functional abilities: _____

Other Important Information (Equipment, etc.): _____

Allergies (Foods/Medications): _____

Emergency Contact (Name/Relationship/Phone Number): _____

Primary Health Care Provider (Name/Phone Number): _____

Primary Hospital (Name/Address/Phone Number): _____

Specialty Health Care Providers (Names/Phone Numbers): _____

BRIEF MEDICAL HISTORY

Diagnosis(es)

Date

_____	_____
_____	_____
_____	_____

BRIEF SURGICAL HISTORY

Procedures

Date

_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS

Name of Medication

Dosage/Frequency

Time of Day Given

Prescribing Physician

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CCS SAN FRANCISCO
EXIT SUMMARY

Client Name: _____

CCS #: _____

MEDICAL CARE

Primary Care Physician

Name: _____

Phone: _____

Address: _____

Dentist

Name: _____

Phone: _____

Address: _____

Specialist

Name/Specialty: _____

Phone: _____

Address: _____

Name/Specialty: _____

Phone: _____

Address: _____

Name/Specialty: _____

Phone: _____

Address: _____

Name/Specialty: _____

Phone: _____

Address: _____

Pharmacy

Name: _____

Phone: _____

Address: _____

Health Insurance

Insurance Company Name: _____

Phone: _____

Policyholder Name: _____

I.D. #: _____

MediCal: ☐ No ☐ Yes MediCal #: _____

SAN FRANCISCO CCS
EXIT SUMMARY

OTHER SERVICES

Contact Name	Phone / Website
<input type="checkbox"/> Rehab Services _____	_____
<input type="checkbox"/> In Home Support Services _____	_____
<input type="checkbox"/> Transportation _____	_____
<input type="checkbox"/> SSI/Financial _____	_____
<input type="checkbox"/> GGRC _____	_____
<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____	_____

EQUIPMENT/SUPPLIES

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

Completed by: _____

Date: _____

CCS SAN FRANCISCO

TRANSITION POLICY & PROCEDURES

POLICY:

California Children's Services will provide support to clients and families in planning for transition to adulthood (SF-TR-01).

PROCEDURES:

For every client at age 14 years (or upon entry to the program), the following procedure will be followed:

- 1) **Flyers (SF-TR-02)** will be sent to all clients by authorization clerks at annual renewal time, starting at age 14.

- 2) A **Transition Screening Tool (SF-TR-03)** will be initiated and placed in the chart.

Responsible party:

☐ **CASE MANAGER:**

- Non-MTU clients.
- All clients: look for the form at annual review and contact the MTU if the form is absent.

☐ **MTU THERAPIST:**

- All MTU clients.
- Send copy of Transition Screening Tool to case manager annually when completed.

Case manager and therapist should coordinate on all shared cases.

Use of the form:

- This form will be updated annually. Individual completing form must sign (not initial) and date where indicated.
- All updates completed at the MTU will be sent to the case manager.
- A case management narrative can be written if further information needs to be documented.
- Any medical records released to the family should be listed in the case management narrative.

- 3) The **Transition Guideline (SF-TR-04)** will be used as a guide for discussions with families, and will be placed in the chart with the Screening Tool. The Screening tool can be provided to families and can be used to assist case managers and therapists in treatment planning, if appropriate.

- 4) The following forms are optional and can be shared with families as resources

- **Health Care Topics (SF-TR-05)**
- **Health Care Skills Check List (SF-TR-06)**
- **Medical History/Emergency Worksheet (SF-TR-07)**
- **Exit Summary (SF-TR-08)**

Any forms shared with families should be documented by checking the appropriate box on the **Transition Screening Tool**. If staff has access to completed forms, they should be placed in the chart.

CCS SAN FRANCISCO TRANSITION SCREENING TOOL

This tool is designed to assist families in identifying initial transition needs while making contact during the annual review process. A more in-depth discussion can follow as a result of this initial screening. Review the suggested discussion topics and complete the appropriate sections with the family. Use the TRANSITION GUIDELINE checklist to discuss age appropriate services. This tool should be kept in the client's medical chart beginning at age 14.

Name:

Date of Birth:

CCS#:

☐ MTU

Transition-Related Topics	
<ul style="list-style-type: none"> ➤ Define/explain CCS transition: <i>the period of time when your child is moving from childhood to adulthood</i> ➤ Briefly discuss the client's medical condition including treatment and understanding of the condition ➤ Confirm Primary Care Provider/Medical Home or make referral to adult provider ➤ Discuss dental issues if applicable and make referral to CCS Dental Consultant ➤ Confirm health care coverage and/or refer client to Eligibility Worker if applicable ➤ Refer to resources including healthcare, dental, SSI, education, employment, and other areas 	
Age 14 Referral to: <input type="checkbox"/> Eligibility Worker <input type="checkbox"/> Social Worker <input type="checkbox"/> Parent Liaison <input type="checkbox"/> Support for Families <input type="checkbox"/> Other _____ Transition meeting? Y or N Time/Date: _____ Notes/Follow-up: Completed by: _____ Date: _____	Age 15 Referral to: <input type="checkbox"/> Eligibility Worker <input type="checkbox"/> Social Worker <input type="checkbox"/> Parent Liaison <input type="checkbox"/> Support for Families <input type="checkbox"/> Other _____ Transition meeting? Y or N Time/Date: _____ Notes/Follow-up: Completed by: _____ Date: _____
Age 16 Referral to: <input type="checkbox"/> Eligibility Worker <input type="checkbox"/> Social Worker <input type="checkbox"/> Parent Liaison <input type="checkbox"/> Support for Families <input type="checkbox"/> Other _____ Transition meeting? Y or N Time/Date: _____ Notes/Follow-up: Completed by: _____ Date: _____	Age 17 Referral to: <input type="checkbox"/> Eligibility Worker <input type="checkbox"/> Social Worker <input type="checkbox"/> Parent Liaison <input type="checkbox"/> Support for Families <input type="checkbox"/> Other _____ Transition meeting? Y or N Time/Date: _____ Notes/Follow-up: Completed by: _____ Date: _____
Age 18 Referral to: <input type="checkbox"/> Eligibility Worker <input type="checkbox"/> Social Worker <input type="checkbox"/> Parent Liaison <input type="checkbox"/> Support for Families <input type="checkbox"/> Other _____ Transition meeting? Y or No Time/Date: _____ Notes/Follow-up: Completed by: _____ Date: _____	Age 19 Referral to: <input type="checkbox"/> Eligibility Worker <input type="checkbox"/> Social Worker <input type="checkbox"/> Parent Liaison <input type="checkbox"/> Support for Families <input type="checkbox"/> Other _____ Transition meeting? Y or N Time/Date: _____ Notes/Follow-up: Completed by: _____ Date: _____
Age 20 Referral to: <input type="checkbox"/> Eligibility Worker <input type="checkbox"/> Social Worker <input type="checkbox"/> Parent Liaison <input type="checkbox"/> Support for Families <input type="checkbox"/> Other _____ Transition meeting? Y or N Time/Date: _____ Notes/Follow-up: Completed by: _____ Date: _____	Discuss and mail appropriate forms to family if requested: <input type="checkbox"/> <u>HEALTH CARE TOPICS</u> <input type="checkbox"/> <u>HEALTH CARE SKILLS CHECKLIST</u> <input type="checkbox"/> <u>MEDICAL HISTORY/EMERGENCY WORKSHEET</u> <input type="checkbox"/> <u>EXIT SUMMARY</u> <input type="checkbox"/> Copy of medical record offered <input type="checkbox"/> Other resources requested:
<input type="checkbox"/> FINAL CONTACT BEFORE CASE CLOSURE (telephone call or transition meeting) Signed by: _____ Date: _____	



SUPPORT FOR FAMILIES

REFERRAL FORM PLEASE PRINT CLEARLY

Please Refer to Support for Families

Name:	Address: 1663 Mission St. 700, SF, CA 94103	
Phone: (415) 920-5040	Email: referral@supportforfamilies.org	Fax: (415) 282-1226

Person making referral:

Name:	Parent/Guardian Initials:	
Referring Agency:		
Address:		
Phone:	Email:	Referral Date:

Child/Family information:

Child Name:	UCI #	Gender: M F
Child DOB:	Child Ethnicity:	
Parent/Guardian Name:	Language Spoken at Home:	
Address:	Parent/Guardian Ethnicity:	
City:	Zip:	
Phone:	Email:	

☐ Lanterman ☐ Early Start ☐ At Risk ☐ Other

I am concerned about my child's (please check all that apply)...

- ☐ Behavior ☐ Hearing Motor & Physical Development ☐ Diagnosis of _____
- ☐ Speech & Language Development ☐ Other _____
- ☐ Prematurity

I give permission to Support for Families and the agencies or individuals initialed above to share pertinent information regarding my child

Medical ☐ Social ☐ Psychological ☐ Developmental ☐ Other _____

Initials I UNDERSTAND THAT:

- _____ The shared information will only be used to coordinate and plan resources and referrals for my child and confidentiality will be maintained.
- _____ I may rescind my permission at any time by writing a note to the agencies/individuals. Expires _____
- _____ A photocopy of this form is as valid as the original and I request a copy

☐ I agree to have a staff member of Support for Families contact me.

Parent/Guardian Signature _____ Date: _____

Parent/Guardian Printed Name: _____
3/12/12



SUPPORT FOR FAMILIES

Forma De Referir Por favor escriba claro

Por favor referir a Support for Families

Nombre:	Direccion: 1663 Mission St. 700, SF, CA 94103	
Tel: (415) 920-5040	Email: referral@supportforfamilies.org	Fax: (415) 282-1226

Persona que hace la referencia:

Nombre:	Familia y hijo/hija iniciales:	
Agencia de referencia:		
Direccion:		
Telefono:	Email:	Fecha de referencia:

Informacion de familia y hijo/hija :

Nombre de hijo/a:	UCI #	Genero: M F
Fecha de nacimiento:	Etnicidad:	
Nombre de padre/madre:	Lengua que habla en casa:	
Direccion:	Etnicidad de madre/padre:	
Ciudad:	Codigo postal:	
Telefono:	Email:	

☐ Lanterman ☐ Early Start ☐ At Risk ☐ Other

Estamos preocupados acerca de (por favor señale lo que aplica)

- ☐ Comportamiento ☐ Desarrollo de motor fisico ☐ Diagnostico de _____
☐ Desarrollo de habla y lenguaje ☐ Otro _____
☐ Prematuro

Doy permiso a Support for Families y la agencia y individuales para compartir informacion (hacia arriba) sobre mi hijo/a.

Medica ☐ Social ☐ Psychological ☐ de desarrollo ☐ Otro _____

Iniciales YO ENTIENDO QUE:

_____ La informacion compartida solo sera utilizada para coordinar y planificar recursos y referencias para mi hijo y la confidencialidad se mantendra.

_____ Puedo rescindir mi permiso en cualquier momento por escrito una nota a las agencias. Vencimiento: _____

_____ Una fotocopia de este formulario es tan valida como el original y solicitar una copia.

☐ Doy permiso a los trabajadores de Support For Families que me contacten.

Padre/madre -Firma _____ Fecha: _____

Padre/madre escriba Nombre _____
3/12/12



SUPPORT FOR FAMILIES

轉介表格 請填寫清楚

請轉介到家庭支援中心

姓名:	地址: 1663 Mission St. 700, SF, CA 94103		
電話: (415) 920-5040	電郵: referral@supportforfamilies.org	傳真: (415) 282-1226	

提出轉介的人:

姓名:	家長/監護人姓名 簡答	
轉介的機構:		
地址:		
電話:	電郵:	轉介日期:

孩子/家庭資料:

兒童姓名:	DCI 號碼:	性別: 男 女
孩子出生日期:	孩子族裔:	
家長/監護人姓名:	在家用的語言:	
地址:	家長/監護人族裔:	
城市:	郵區:	
電話:	電郵:	

☐ Lanterman ☐ 早期開始 ☐ 有風險 ☐ 其他

我關注有關我的孩子的 (請指出所有適合的)

- ☐ 行為 ☐ 溝通, 運動及身體發展 ☐ 診斷 _____
- ☐ 語言發展 ☐ 其他 _____
- ☐ 早產

我簡簽同意允許機構共享以上關於我的孩子個人的相關信息

醫療 ☐ 社交 ☐ 心理發展 ☐ 其它 _____ ☐

簡簽 我明白以下:

- _____ 共享信息將僅用於協調和規劃我孩子的資源和轉介, 將會保密。
- _____ 我可以在任何時候寫一數字標記機構去撤銷我的同意書。 過期 _____
- _____ 此 複印文件的形式和原始的文件一樣有效, 我要求一個副本。

- ☐ 我同意家庭支援中心的工作人員與我聯繫。

家長/監護人簽名: _____ 日期: _____

家長/監護人姓名: _____

3/12/12

— Blank Page —

Date: _____

Re: Request for Assessment

To Whom It May Concern:

I am requesting that my child, _____, birth date _____, be assessed by the San Francisco Unified School District [California Education Code (Cal. Ed. Code) Secs. 56229, 56301, 56302, and 56331(a); 5 California Code of Regulations (C.C.R.) Sec. 3031.]. My child currently attends _____ and is the _____ grade. This assessment will be one of the following (please check one):

☐ initial *psychological-educational assessment* ☐ three year re-evaluation

☐ other _____

Some of the concerns I have are:

I am also requesting that my child be evaluated for the presence of any educational service need, which may require accommodations or program modification not available under special education, but my fall under services provided through 504 of the Rehabilitation Act.

I look forward to receiving an assessment plan in 15 days [Cal. Ed. Code Sec. 56331(a)]. I hope these evaluations can be completed promptly. Thereafter we can have an IEP meeting to discuss these evaluations and plan for my child's continued education. I am aware that this meeting should be scheduled within 60 days after I return a signed copy of the assessment plan [Cal. Ed. Code Sec. 56344]. I would like all pertinent SFUSD assessment staff to be present at the initial IEP meeting to discuss the results and recommendations of the assessment and evaluation. Please ensure that I receive copies of the assessment reports one week before the IEP meeting.

You can reach me at:

Name: _____

Address: _____

Telephone: _____

Thank you for your cooperation and assistance.

Sincerely,

(parent/guardian)

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Modified Checklist for Autism in Toddlers (M-CHAT)* - Scoring

Diana L. Robins, M.A., Deborah Fein, Ph.D., Marianne L. Barton, Ph.D., & James A. Green,

Ph.D.

University of Connecticut

*The full text may be obtained through the Journal of Autism and Developmental Disorders,

April 2001

PLEASE NOTE: The M-CHAT was not designed to be scored by the person taking it. In the validation sample, the authors of the M-CHAT scored all checklists. If parents are concerned, they should contact their child's physician .

Abstract

Autism, a severe disorder of development, is difficult to detect in very young children. However, children who receive early intervention have improved long-term prognoses. The Modified – Checklist for Autism in Toddlers (M-CHAT), consisting of 23 yes/no items, was used to screen 1076 children. Thirty of 44 children given a diagnostic/developmental evaluation were diagnosed with a disorder on the autism spectrum. Nine items pertaining to social relatedness and communication were found to have the best discriminability between children diagnosed with and without autism/PDD. Cutoff scores were created for the best items and the total checklist. Results indicate that the M-CHAT is a promising instrument for the early detection of autism.

Background

The M-CHAT is an expanded American version of the original CHAT from the U.K. The M-CHAT has 23 questions using the original nine from the CHAT as its basis. Its goal is to improve the sensitivity of the CHAT and position it better for an American audience.

The M-CHAT has been steadily expanding its radius of usage in the state of Connecticut and surrounding New England states. Its authors are still collecting data on the initial study, awaiting final outcomes for sensitivity and specificity after the subjects return for their 3.5 year well-child visit by 2003. The authors have applied for funding of an expanded study on 33,000 children. The M-CHAT tests for autism spectrum disorders against normally developing children.

M-CHAT Scoring Instructions

A child fails the checklist when 2 or more critical items are failed OR when any three items are failed. Yes/no answers convert to pass/fail responses. Below are listed the failed responses for each item on the M-CHAT. Bold capitalized items are CRITICAL items.

Not all children who fail the checklist will meet criteria for a diagnosis on the autism spectrum. However, children who fail the checklist should be evaluated in more depth by the physician or referred for a developmental evaluation with a specialist.

1. No	6. No	11. Yes	16. No	21. No
2. NO	7. NO	12. No	17. No	22. Yes
3. No	8. No	13. NO	18. Yes	23. No
4. No	9. NO	14. NO	19. No	
5. No	10. No	15. NO	20. Yes	

Modified Checklist for Autism in Toddlers (M-CHAT) - Spanish

— Blank Page —

Nombre del paciente

Apellido del paciente

Fecha

M-CHAT SPANISH

Seleccione, rodeando con un círculo, la respuesta que le parece que refleja mejor cómo su hijo o hija actúa NORMALMENTE. Si el comportamiento no es el habitual (por ejemplo, usted solamente se lo ha visto hacer una o dos veces) conteste que el niño o niña NO lo hace. Por favor, conteste a todas las preguntas.

1. ¿Le gusta que le balanceen, o que el adulto le haga el “caballito” sentándole en sus rodillas, etc.?	Sí	No
2. ¿Muestra interés por otros niños o niñas?	Sí	No
3. ¿Le gusta subirse a sitio como, por ejemplo, sillones, escalones, juegos del parque...?	Sí	No
4. ¿Le gusta que el adulto juegue con él o ella al “cucu-tras” (taparse los ojos y luego descubrirlos; jugar a esconderse y aparacer de repente)?	Sí	No
5. ¿Alguna vez hace juegos imaginativos, por ejemplo hacienda como si hablara por teléfono, como si estuviera dando de comer a una muñeca, como si estuviera conduciendo un coche o cosas así?	Sí	No
6. ¿Suele señalar con el dedo para pedir algo?	Sí	No
7. ¿Suele señalar con el dedo para indicar que algo le llama la atención?	Sí	No
8. ¿Puede jugar adecuadamente con piezas o juguetes pequeños (por ejemplo cochecitos, muñequitos o bloques de construcción) sin únicamente chuparlos, agitarlos, o tirarlos?	Sí	No
9. ¿Suele traerle objetos para enseñárselos?	Sí	No
10. ¿Suele mirarle a los ojos durante unos segundos?	Sí	No
11. ¿Le parece demasiado sensible a ruidos poco intensos? (por ejemplo, reacciona tapándose los oídos, etc.)	Sí	No
12. ¿Sonríe al verle a usted o cuando usted le sonríe?	Sí	No
13. ¿Puede imitar o repetir gestos o acciones que usted hace? (por ejemplo, si usted hace una mueca él o ella también la hace)?	Sí	No
14. ¿Responde cuando se le llama por su nombre?	Sí	No
15. Si usted señala con el dedo un juguete al otro lado de la habitación... ¿Dirige su hijo o hija la mirada hacia ese juguete?	Sí	No
16. ¿Ha aprendido ya a andar?	Sí	No
17. Si usted está mirando algo atentamente, ¿su hijo o hija se pone también a mirarlo?	Sí	No
18. ¿Hace su hijo o hija movimientos raros con los dedos, por ejemplo, acercándoselos a los ojos?	Sí	No
19. ¿Intenta que usted preste atención a las actividades que él o ella está haciendo?	Sí	No
20. ¿Alguna vez ha pensado que su hijo o hija podría tener sordera?	Sí	No
21. ¿Entiende su hijo o hija lo que la gente dice?	Sí	No
22. ¿Se queda a veces mirando al vacío o va de un lado al otro sin propósito?	Sí	No
23. Si su hijo o hija tiene que enfrentarse a una situación desconocida, ¿le mira primero a usted a la cara para saber cómo reaccionar?	Sí	No

REFERIR (MARCA LO QUE APLICA):

☐ Audiology ☐ Community Resources ☐ RCEB ☐ Other: _____
☐ School District ☐ SART Linkage Line ☐ Speech ☐ Other: _____

Circula el Resultado:

PASA or REPRUEBA

Modified Checklist for Autism in Toddlers (M-CHAT) - English

Patient's First Name

Patient's Last Name

Date

M-CHAT

Please fill out the following about how the child usually is. Try to answer every question. If the behavior is rare (you've seen it only once or twice), please answer as if the child does not do it.

A child fails the checklist when 2 or more critical items are failed OR when any 3 items are failed.

Bold items are critical items. Circle response if failed.

1. Does your child enjoy being swung, bounced on your knee, etc.?	Yes	No
2. Does your child take an interest in other children?	Yes	No
3. Does your child like climbing on things, such as up stairs?	Yes	No
4. Does your child enjoy playing peek-a-boo/hide-and-seek?	Yes	No
5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	Yes	No
6. Does your child ever use his/her index finger to point, to ask for something?	Yes	No
7. Does your child ever use his/her index finger to point, to indicate something of interest?	Yes	No
8. Can your child play properly with small toys (such as cars or blocks) without just mouthing, fiddling, or dropping them?	Yes	No
9. Does your child ever bring objects over to you (the parent) to show you something?	Yes	No
10. Does your child look you in the eye for more than a second or two?	Yes	No
11. Does your child ever seem oversensitive to noise (i.e. plugging ears)?	Yes	No
12. Does your child smile in response to your face or your smile?	Yes	No
13. Does your child imitate you? (such as, you make a face, will your child imitate it?)	Yes	No
14. Does your child respond to his/her name when you call?	Yes	No
15. If you point at a toy across the room, does your child look at it?	Yes	No
16. Does your child walk?	Yes	No
17. Does your child look at things you are looking at?	Yes	No
18. Does your child make unusual finger movements near his/her face?	Yes	No
19. Does your child try to attract your attention to his/her activity?	Yes	No
20. Have you ever wondered if your child is deaf?	Yes	No
21. Does your child understand what people say?	Yes	No
22. Does your child sometimes stare at nothing or wander with no purpose?	Yes	No
23. Does your child look at you face to check your reaction when faced with something unfamiliar?	Yes	No

REFER FOR (CHECK ALL THAT APPLY):

☐ Audiology
 ☐ Community Resources
 ☐ RCEB
 ☐ Other: _____
☐ School District
☐ SART Linkage Line
☐ Speech
☐ Other: _____

Circle Score:

PASS or FAIL

© 1999 Diana Robins, Deborah Fein, & Marianne Barton

Rev 03.05.2010

Website <http://www.firstsigns.org/downloads/m-chat.pdf>

Sources <http://www.dbpeds.org/media/mchat.pdf> (Developmental Behavioral Pediatrics Online)

Modified Checklist for Autism in Toddlers (M-CHAT) - Scoring

M-CHAT OVERLAY

A child fails the checklist when 2 or more critical items are failed OR when any 3 items are failed. Red/bordered items are critical items.

The black out section is the correct answer. The non-black out section indicates risk for autism.

1. Does your child enjoy being swung, bounced on your knee, etc.?		No
2. Does your child take an interest in other children?		No
3. Does your child like climbing on things, such as up stairs?		No
4. Does your child enjoy playing peek-a-boo/hide-and-seek?		No
5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?		No
6. Does your child ever use his/her index finger to point, to ask for something?		No
7. Does your child ever use his/her index finger to point, to indicate something of interest?		No
8. Can your child play properly with small toys (such as cars or blocks) without just mouthing, fiddling, or dropping them?		No
9. Does your child ever bring objects over to you (the parent) to show you something?		No
10. Does your child look you in the eye for more than a second or two?		No
11. Does your child ever seem oversensitive to noise (i.e. plugging ears)? REVERSE	Yes	
12. Does your child smile in response to your face or your smile?		No
13. Does your child imitate you? (such as, you make a face, will your child imitate it?)		No
14. Does your child respond to his/her name when you call?		No
15. If you point at a toy across the room, does your child look at it?		No
16. Does your child walk?		No
17. Does your child look at things you are looking at?		No
18. Does your child make unusual finger movements near his/her face? REVERSE	Yes	
19. Does your child try to attract your attention to his/her activity?		No
20. Have you ever wondered if your child is deaf? REVERSE	Yes	
21. Does your child understand what people say?		No
22. Does your child sometimes stare at nothing or wander with no purpose? REVERSE	Yes	
23. Does your child look at you face to check your reaction when faced with something unfamiliar?		No

Modified Checklist for Autism in Toddlers (M-CHAT) - Scoring

M-CHAT SPANISH

El niño reprueba la lista de chequeo si falla en 2 o más de las preguntas críticas o si falla en 3 de las preguntas. Las preguntas con borde rojo se consideran críticas. Las respuestas correctas están sombreadas en negro. Las respuestas que no están sombreadas son respuestas que indica que hay riesgo de autismo.

1. ¿Le gusta que le balanceen, o que el adulto le haga el “caballito” sentándole en sus rodillas, etc.?		No
2. ¿Muestra interés por otros niños o niñas?		No
3. ¿Le gusta subir a sitio como, por ejemplo, sillones, escalones, juegos del parque...?		No
4. ¿Le gusta que el adulto juegue con él o ella al “cucu-tras” (taparse los ojos y luego descubrirlos; jugar a esconderse y aparacer de repente)?		No
5. ¿Alguna vez hace juegos imaginativos, por ejemplo hacienda como si hablara por teléfono, como si estuviera dando de comer a una muñeca, como si estuviera conduciendo un coche o cosas así?		No
6. ¿Suele señalar con el dedo para pedir algo?		No
7. ¿Suele señalar con el dedo para indicar que algo le llama la atención?		No
8. ¿Puede jugar adecuadamente con piezas o juguetes pequeños (por ejemplo cochecitos, muñequitos o bloques de construcción) sin únicamente chuparlos, agitarlos, o tirarlos?		No
9. ¿Suele traerle objetos para enseñárselos?		No
10. ¿Suele mirarle a los ojos durante unos segundos?		No
11. ¿Le parece demasiado sensible a ruidos poco intensos? (por ejemplo, reacciona tapándose los oídos, etc.)	INVERSO	Sí
12. ¿Sonríe al verle a usted o cuando usted le sonríe?		No
13. ¿Puede imitar o repetir gestos o acciones que usted hace? (por ejemplo, si usted hace una mueca él o ella también la hace)?		No
14. ¿Responde cuando se le llama por su nombre?		No
15. Si usted señala con el dedo un juguete al otro lado de la habitación... ¿Dirige su hijo o hija la mirada hacia ese juguete?		No
16. ¿Ha aprendido ya a andar?		No
17. Si usted está mirando algo atentamente, ¿su hijo o hija se pone también a mirarlo?		No
18. ¿Hace su hijo o hija movimientos raros con los dedos, por ejemplo, acercándose a los ojos?	INVERSO	Sí
19. ¿Intenta que usted preste atención a las actividades que él o ella está haciendo?		No
20. ¿Alguna vez ha pensado que su hijo o hija podría tener sordera?	INVERSO	Sí
21. ¿Entiende su hijo o hija lo que la gente dice?		No
22. ¿Se queda a veces mirando al vacío o va de un lado al otro sin propósito?	INVERSO	Sí
23. Si su hijo o hija tiene que enfrentarse a una situación desconocida, ¿le mira primero a usted a la cara para saber cómo reaccionar?		No

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Golden Gate Regional Center (GGRC)

875 Stevenson Street - 6th Floor

San Francisco, CA 94103

(415) 546-9222

Fax: (415) 546-9203

www.ggrc.org

GOLDEN GATE REGIONAL CENTER SERVES CHILDREN AT RISK FOR A DEVELOPMENTAL DISABILITY AND PERSONS WITH DEVELOPMENTAL DISABILITIES AND THEIR FAMILIES. ELIGIBLE INDIVIDUALS CAN RECEIVE SERVICES THROUGHOUT THEIR LIVES.

Eligibility (0-3)	<p><i>Early Start Eligibility:</i></p> <ul style="list-style-type: none">▪ An infant or toddler under 24 months of age will be eligible for the Early Start program if he or she exhibits a 33% delay in one or more of the following areas of development : cognitive development; physical and motor development, including vision and hearing; communication; social or emotional development and adaptive development; Adjusted age is used up to age 24 months.▪ An infant or toddler 24 months of age or older must exhibit a 50% delay in one area of development or a 33% delay in 2 or more areas.▪ For children ages 24 months or older, the 33% delay in two areas must be in two different areas or developmental domains. Fine and gross motor (motor) and receptive and expressive language (communication) count as 1 area each.▪ The age used for eligibility is the age at the time of the <u>initial referral, not the date of the assessment.</u> <p><i>Prevention Program Eligibility</i></p> <ul style="list-style-type: none">▪ An infant or toddler who is at risk of having a substantial developmental disability due to a combination of two or more biomedical high risk factors.▪ An infant or toddler who is 24-35 months of age and does not meet the eligibility for the Early Start program but has a delay in one area of development that is between 33% and 49% .▪ Services to be provided in this program are evaluation and assessment, case management and referral to generic resources.
Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none">- Assistive technology devices and assistive technology services- Audiology services- Family training, counseling, and home visits- Health services necessary to enable the infant or toddler to benefit from other early intervention services- Medical services for diagnostic/evaluation purposes only- Nursing services- Nutrition services- Occupational therapy- Physical therapy- Psychological services- Respite services

CALIFORNIA CHILDREN'S SERVICES
SAN FRANCISCO

"TRANSITIONING TO ADULTHOOD"



At age 21 your child will no longer be eligible for California Children's Services (CCS). CCS offers transition planning for healthcare services. Transition planning means preparing for the movement of adolescents and young adults from child-centered to adult-oriented services and systems. It can include:

- Obtaining information on changes in services and legal status which will occur as a child reaches adulthood.
- Identifying healthcare needs and adult providers.
- Understanding the available supports and services.
- Identifying steps toward independence for individuals and their families.
- Coordinating with other agencies that provide education, employment, recreation and independent or supported living.

If you would like help with transition planning, please contact your CCS Case Manager at 575-5700 or MTU therapist at 759-2919.

This section is Official Use Only:

Service Coordinator:	Date Packet Sent:	UCI:	Date Assigned:
Intake By:	45 Days:	<input type="checkbox"/> Check if caller/referrer has been advised to provide reports	

GOLDEN GATE REGIONAL CENTER - EARLY START PARENT INTAKE FORM

Child's Last Name:		Child's First Name:		Date of Birth:	Sex:
Date:	Referral Source:			Referrer's Phone # / Fax # / Email:	
Parent(s)'s Name: <input type="checkbox"/> Married			Language(s) Spoken in House: <input type="checkbox"/> Not Fluent in English		
Contact Phone #:		Contact Email:		Child's Insurance Provider:	
Physical Address: <input type="checkbox"/> Check if mailing address is different (and list below)				Child's Birth Hospital:	
Professional/ Specialist/ Agency that has seen your child, if any (e.g. school district, etc):				Child's Primary Care Physician:	

Over the age of Three

For developmental disability concerns for a person over the age of three, please call 1-888-339-3305.

Early Start Services

To be eligible for Golden Gate Regional Center Early Start services, your child must meet the following criteria:

- Within 0-36 months old;
- Developmentally delayed, or having a diagnosis that will lead to a developmental disability.

*If the concern is for **SPEECH**, please describe the concern with information regarding the following items:*

- | | |
|--|---|
| • Ever had a hearing test done? If yes, what was the result? | <input type="checkbox"/> Y <input type="checkbox"/> N - |
| • Amount of clear and unclear words | Clear Words # - ; Unclear Words # - |
| • Any 2 or more word phrases/ sentences? | <input type="checkbox"/> Y <input type="checkbox"/> N - |
| • Responsive & follows commands well? | <input type="checkbox"/> Y <input type="checkbox"/> N - |
| • Eye contact well maintained? | <input type="checkbox"/> Y <input type="checkbox"/> N - |

*If the concern is for **MOTOR**, please describe the concern with information regarding the following items:*

- | | |
|--|---|
| • Able to sit up without support? | <input type="checkbox"/> Y <input type="checkbox"/> N - |
| • Able to crawl? | <input type="checkbox"/> Y <input type="checkbox"/> N - |
| • Able to pull to stand? | <input type="checkbox"/> Y <input type="checkbox"/> N - |
| • Able to walk? | <input type="checkbox"/> Y <input type="checkbox"/> N - |
| • Do you notice either floppiness/ stiffness in the muscles? | <input type="checkbox"/> Y <input type="checkbox"/> N - |

NOTE: If your child has been treated or evaluated for the concern(s), please attach a copy of all pertinent medical records and/or any evaluation(s) detailing the diagnoses and treatments with this form.

Additional comments/diagnosis or concern(s) in other areas of development:	
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Please ATTACH and EMAIL this form & related reports to **intake@ggrc.org** with subject "Early Start Referral" OR FAX it to 1-888-339-3306. If you have any questions, please call 1-888-339-3305 or email **intake@ggrc.org**.

