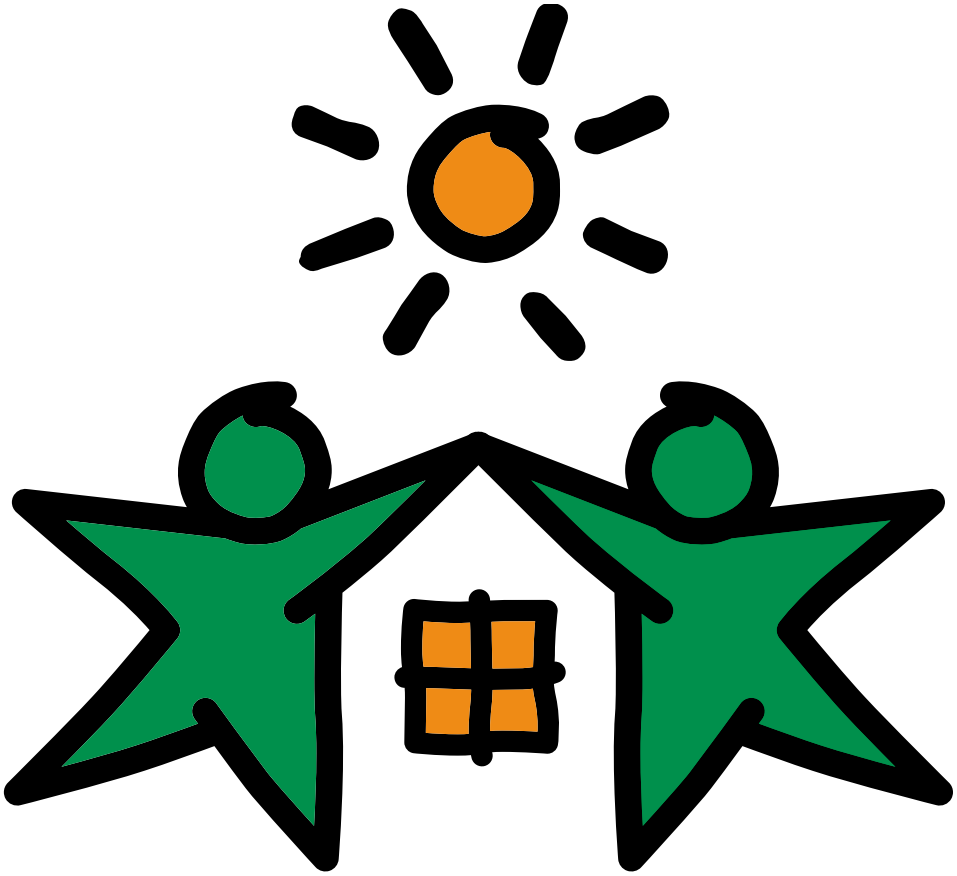
The Alameda County Medical Home Project



Resources for Children with Special Health Care Needs and their Families

January 2016

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

FIRST 5 ALAMEDA COUNTY

ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT

Medical Home activities are supported by Lucile Packard Children's Hospital, First 5 Alameda County and Alameda County Public Health Department

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Alameda County Public Health Department

Please Note: The ACMHP has made every effort to ensure that the information contained herein is accurate to date. We apologize for any errors that may have occurred in the preparation of this resource. This information is designed to be shared with others who may benefit from it. Photo-copying information from this binder and/or electronic file sharing of portable document format (pdf) files contained on the companion ACMHP CD-Rom is permissible.

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Alameda 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 ***Alameda 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

The Alameda County Medical Home Project (ACMHP)
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The Medical Home

The AAP and 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 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).

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

Contact Information

(847) 434-4000
(847) 434-8000 FAX
National Center of Medical Home Initiatives for Children with Special Needs
American Academy of Pediatrics
141 Northwest Point Blvd, Elk Grove Village, IL 60007
email **medical_home@aap.org**
Web site **http://www.medicalhomeinfo.aap.org**
AAP Policy site **http:// http://pediatrics.aappublications.org/site/aappolicy/index.xhtml**

Center for Medical Home Improvement (CMHI)
Crotched Mountain Foundation
18 Low Avenue, Ste. 1
Concord, NH 03301
Web site **http://www.medicalhomeimprovement.org**
email **cmhi@crotchedmountain.org**

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Alameda County Medical Home Project
Medical Home Characteristics

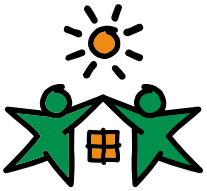
Alameda County Medical Home Project (ACMHP) Characteristics of a Medical Home

	Optimal Medical Home Characteristics
Accessible	• 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	• 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	• 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, Medi-Cal). • 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.

ACMHP Characteristics of a Medical Home (continued)

Optimal Medical Home Characteristics (continued)	
Continuous	• 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	• 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	• 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	• 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

AAH	Alameda Alliance for Health
AAP	American Academy of Pediatrics
ABA	Applied Behavioral Analysis
ACA	Affordable Care Act
ACCESS	Intake/Referral Alameda County Department of Behavioral Health Care Services (BHCS)
ACFJC	Alameda County Family Justice Center
ACMHP	Alameda County Medical Home Project
ACPHD	Alameda County Public Health Department
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactive Disorder
AHTP	Adolescent Health Transition Project
ASD	Autism Spectrum Disorder
ASL	American Sign Language
ASQ	Ages and Stages Questionnaire
AT	Assistive Technology
AUT	Autism or Autism-like (IDEA disability category)

B

BHCS	Department of Behavioral Health Care Services

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
CEC	Council for Exceptional Children
CH	Communicatively Handicapped
CHAMP	Children's Health Access and Medical Program
CHDP	Child Health & Disability Prevention Program
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
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
E	
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. Referral by special education IEP team typically for county Mental Health or California Children's Services (CCS) support services for eligible student
F	
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
FRC	Family Resource Center
FRN	Family Resource Navigators
FSP	Food Stamp Program
FVLC	Family Violence Law Center
G	
GHPP	Genetically Handicapped Persons Program
H	
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)
HMG	Help Me Grow
HMO	Health Maintenance Organization
I	
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
ILSP	Independent Living Skills Program
IPP	Individual Program Plan (Regional Center plan for eligible individuals)
K	
KP	Kaiser Permanente
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	
MCAP	Medi-Cal Access Program
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)
PPP	Prevention Program Plan (Regional Center)
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
RCEB	Regional Center of the East Bay
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)
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 U V W

TANF	Temporary Assistance to Needy Families (CalWORKS; formerly AFDC)
TBI	Traumatic Brain Injury (IDEA disability category)
UCP	United Cerebral Palsy
VH	Visually Handicapped
VI	Visual Impairment (IDEA disability category)
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

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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

CMHI Downloads

Both the full 25-item Medical Home Index and the following 10-item MHI: Short Version can be downloaded from the CMHI website:
www.medicalhomeimprovement.org
www.medicalhomeimprovement.org/knowledge/practices.html

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)
# 1 Family Feedback ***Requires both MD & key non-MD staff person's perspective.*** *(# 1.5 MHI-Full Version)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	Feedback from families of ***CSHCN*** 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. ❒ **PARTIAL** ❒ **COMPLETE**	An advisory process is in place with families of ***CSHCN*** 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). ❒ **PARTIAL** ❒ **COMPLETE**
# 2 Cultural Competence *(# 1.6 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **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. ❒ **PARTIAL** ❒ **COMPLETE**	Family assessments include pertinent cultural information, particularly about health beliefs; this information is incorporated into care plans; the ***practice*** uses these encounters to assess patient & community cultural needs. ❒ **PARTIAL** ❒ **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. ❒ **Level 1**	A ***CSHCN*** list is generated by applying a definition (see pg. 6), the list is used to enhance care +/or define ***practice*** activities (e.g. to flag charts and computer databases for special attention or identify the population and its subgroups). ❒ **PARTIAL** ❒ **COMPLETE**	Diagnostic codes for ***CSHCN*** are documented, problem lists are current, and complexity levels are assigned to each child; this information creates an accessible ***practice*** database. ❒ **PARTIAL** ❒ **COMPLETE**

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)
#4 Care Continuity *(# 2.2 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **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. ❒ **PARTIAL** ❒ **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. ❒ **PARTIAL** ❒ **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. ❒ **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. ❒ **PARTIAL** ❒ **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). ❒ **PARTIAL** ❒ **COMPLETE**

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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)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	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: • 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. ❒ **PARTIAL** ❒ **COMPLETE**	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). ❒ **PARTIAL** ❒ **COMPLETE**
#7 Care Coordination /Role Definition *(# 3.1 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	Care coordination activities are based upon ongoing assessments of child and family needs; the ***practice*** partners with the family (and older child) to accomplish care coordination goals. ❒ **PARTIAL** ❒ **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. ❒ **PARTIAL** ❒ **COMPLETE**

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. ❒ **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. ❒ **PARTIAL** ❒ **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. ❒ **PARTIAL** ❒ **COMPLETE**
#9 Community Assessment of Needs for CSHCN *(# 4.1 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **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. ❒ **PARTIAL** ❒ **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. ❒ **PARTIAL** ❒ **COMPLETE**
#10 Quality Standards (structures) *(# 6.1 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **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. ❒ **PARTIAL** ❒ **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***. ❒ **PARTIAL** ❒ **COMPLETE**

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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

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.

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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)

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.

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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):

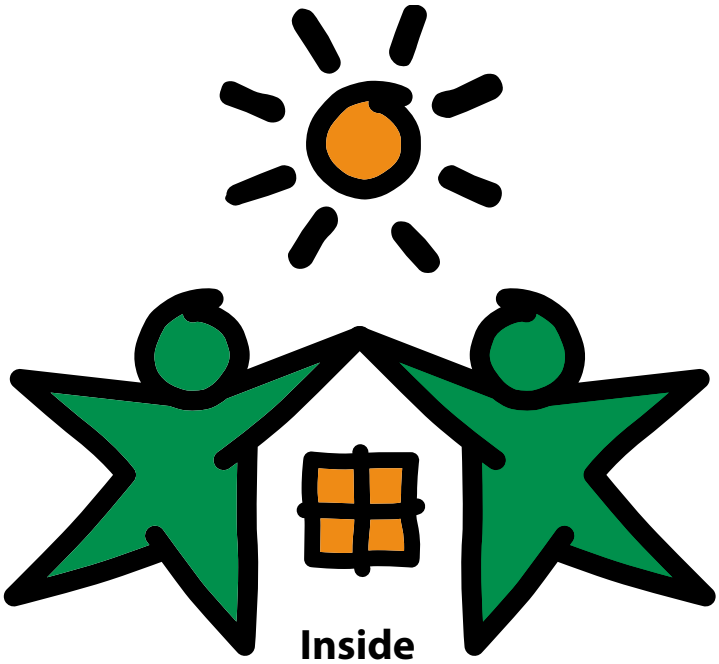
Physician or pediatric nurse practitioner who is considered the main provider of health care for the child

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.

Health Services



Inside

Primary Health Services Programs

- Health Services Overview Chart
- Medi-Cal
- Child Health and Disability Prevention (CHDP) Program
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- Kaiser Permanente Cares for Kids Child Health Plan
- Medi-Cal Access Program (MCAP)

Supplemental Health Services Programs

- California Children's 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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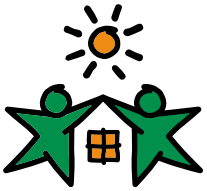
Health Services Overview



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
Provides no-cost* comprehensive health, dental and vision coverage for children and pregnant women. **Eligibility:** Determined by family size, children's ages and family income. **Available** to eligible U.S. citizens, U.S. nationals or immigrants. *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. **(800) 541-5555 Information, toll free** **(510) 777-2300 Information**	**Provides** no-cost well-child screening program for infants, children and teens. Any identified health problems are referred for diagnosis and treatment. **Eligibility:** Those on Medi-Cal (birth up to age 21), or those (birth up to age 19) in families who have income up to 200% of the Federal Poverty Level (FPL). **(510) 618-2070 CHDP Alameda Co** **(510) 981-5300 CHDP Berkeley**
Medi-Cal Access Program (MCAP) (Formerly Access for Infants and Mothers)	**Kaiser Permanente Cares for Kids Child Health Plan**
Provides health insurance for uninsured pregnant women until 60 days after pregnancy has ended. **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. **Total Cost** is 1.5% of family income from pregnancy through 60 days post-partum. **(800) 433-2611 MCAP Info Line/ Application request**	**Provides** low-cost health care coverage for uninsured children who are not eligible for no-cost Medi-Cal, a job based health plan or financial assistance through Covered California. **Available** to children (under age 19) who live within Kaiser Permanente's California service area. **Total Cost** is $0, $10 or $20 per child per month; some co-pays. **Eligibility:** Based on family size/income. **(800) 255-5053 Information/Request Enrollment Packet**

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

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 250% of FPL
- Children aged 0–19 in families with incomes at or below 250% of FPL. Coverage for children "who do not have, or are unable to establish, satisfactory immigration status" will begin May 1, 2016

Public Assistance Recipients

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

- CalWORKs (known federally as TANF, formerly AFDC) recipients
- Supplemental Security Income/State Supplemental Payment (SSI/SSP) recipients

Medically Needy/Medically Indigent/Foster Youth

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
- Youth aging out of foster care, and former foster youth are eligible for Medi-Cal until age 26 as long as they were in foster care on their 18th birthday.

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 Alameda County, the two plans are Alameda Alliance for Health (AAH) and Blue Cross.
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	**Medi-Cal Toll-free** **To apply for Medi-Cal over the phone or to request a mail-in application**
(800) 880-5305	**Toll Free Information Line for Medi-Cal**
(510) 777-2300 **(800) 698-1118**	**Alameda County Social Services** **To apply for Medi-Cal over the phone or to request a mail-in application**
(800) 300-1506	**Covered California** **To apply for Medi-Cal over the phone or to request a mail-in application**
(510) 383-2898	**Alameda County Health Insurance Benefits Coordinator** **Free help with Medi-Cal application**
Web sites	**http://www.alamedasocialservices.org** **http://www.medi-cal.ca.gov** **http://www.coveredca.com/medi-cal/**

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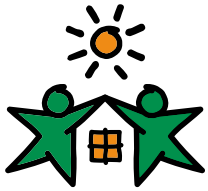
Child Health and Disability Prevention (CHDP) Program



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:

- Health and developmental history
- Physical examination
- Nutritional assessment
- Immunizations
- Vision testing
- Hearing testing
- Lead testing
- Some laboratory tests
  (e.g., tuberculin, sickle cell, urinalysis, hemoglobin/hematocrit, Pap smears)
- Health education and anticipatory guidance.
- Camp and sports physicals.
- Referrals to dentists who accept Medi-Cal
  (Medi-Cal eligible children 3 years of age and over)
- 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?

- Medi-Cal beneficiaries (birth up to age 21) under the regulations of the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
- Non-Medi-Cal eligible children (birth up to age 19) from low-income families
- 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

(510) 618-2070
(510) 618-2077 FAX
Alameda County CHDP
1000 San Leandro Blvd., Suite 200
San Leandro, CA 94577

(510) 981-5300
(510) 981-5395 FAX
City of Berkeley CHDP
1947 Center Street
Berkeley, CA 94704

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

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Covered California

Covered California is California's private, commercial health insurance marketplace created through the federal Affordable Care Act (ACA) for individuals and families ineligible for Medi-Cal who do not have coverage through their employer.

Services What services are provided?
There are four levels of coverage (from the lowest level, Bronze, to the highest, Platinum) available in plans sold through Covered California The levels vary by the percentage of medical expenses that is paid by the health plan; in other words, the lower the level, the higher the out-of-pocket expenses, including premiums, to the insured person or family:

- **Bronze**: 60 percent of covered medical expenses are paid for by the health plan
- **Silver**: 70 percent of covered medical expenses are paid for by the health plan
- **Gold**: 80 percent of covered medical expenses are paid for by the health plan
- **Platinum**: 90 percent of covered medical expenses are paid for by the health plan

Monthly premiums are lowest for bronze coverage and increase up to platinum coverage.

The ACA requires that all health plans sold through Covered California cover ten essential health benefits:

- Ambulatory patient service
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use
- Pediatric services, including oral and vision care
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management

Providers Where are services provided?
Services may be obtained from any physician, clinic or hospital within the insured person's Covered California health plan's network.

Eligibility Who is Eligible?
Individuals who have incomes between 138-400% of the Federal Poverty Level [FPL] and are not eligible for Medi-Cal, and don't have health coverage through an employer may be eligible for subsidized health coverage through Covered California. Plans sold through Covered California are currently available only to legal residents of California.

Reminder: Many children in low-income families may be eligible for Medi-Cal and adults with annual incomes below 138% of FPL also may be eligible for Medi-Cal. These families or individuals who apply to Covered California will be able to apply for Medi-Cal via the Covered California website.

Enrollment Open enrollment runs annually from November to February. Special enrollment is available any time to individuals who experience a qualifying life event, such as losing health coverage through Medi-Cal or one's job, having a child, getting married or entering into a domestic partnership. Individuals may enroll online, by phone or with a certified enrollment counselor or insurance agent. (Local certified enrollers and others who can assist with enrollment can be located using the Covered California website.)

Contact Information

(800) 300-1506
(888)329-3700 FAX

Covered California
P.O. Box 989725
West Sacramento, CA 95798

Web Site **www.coveredca.com**

Kaiser Permanente Cares for Kids Child Health Plan

Kaiser 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?

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

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

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

Eligibility

Who is eligible?

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

Cost

What does it cost?

- Premiums are free or $10 or $20 per child per month
- A family pays for only up to 3 children per family, or a maximum of $60 per month; no premiums are paid for additional children in the family.
- 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?

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

Contact Information

(800) 255-5053

Request an enrollment packet
Kaiser Permanente Child Health Plan
P.O. Box 12904
Oakland, CA 94604

Web site

http://info.kaiserpermanente.org/html/child_health_plan/index.html

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Medi-Cal Access Program (MCAP)

Medi-Cal Access Program (Formerly Access for Infants and Mothers, AIM) provides low-cost health coverage for pregnant women. It is designed for families in the middle income bracket who do not have health insurance and whose income is too high to quality for no-cost Medi-Cal. MAP 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 MAP, her baby automatically qualifies for enrollment in Medi-Cal. Your baby is eligible for coverage in the Medi-Cal Access Infant Program for up to two years, unless your baby is enrolled in employer sponsored insurance or no-cost Medi-Cal or your income no longer qualifies at your infant's first birthday.

Services What services are provided?
All medically necessary services are covered from the time of acceptance into the Medi-Cal Access Program until 60 days after the pregnancy has ended. Services include:

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

- Pregnant women (not more than 30 weeks)
- Must have lived in California for the last 6 months
- Cannot be receiving no-cost Medi-Cal or Medicare benefits
- Cannot have maternity benefits through private insurance, unless coverage has a separate maternity-only deductible or co-payment that is more than $500
- Modified Adjusted Gross Income (after MAP deductions) within the MAP income guidelines (213-322% of Federal Poverty Level) [see Income Limit Tables in this section]

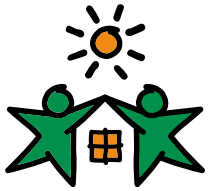
Cost The total cost of MCAP enrollment is 1.5% of the family's income after allowable income deductions; there are no co-payments or deductibles. Payment may be made when the application is submitted, or in monthly payments over one year. This payment covers care during pregnancy and 60 days of post-partum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

Cancellation If MCAP 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 MAP website or Covered California or call for application.

Contact Information	**(800) 433-2611**	**Medi-Cal Access Program** **P.O. Box 15559, Sacramento, CA 95852-0559**
	Web site	**http://www.aim.ca.gov** **http://www.coveredca.com**

California Children's Services (CCS)



California Children's 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 and complication of birth requiring intensive level of care
- Blood disorders, i.e. hemophilia, sickle cell anemia
- Respiratory systems disorders, i.e. cystic fibrosis, chronic lung disease
- Cancer & some other tumors
- Traumatic injuries and poisonings requiring intensive care and rehabilitation, i.e. brain, spinal cord
- Nervous system disorders, i.e. cerebral palsey, uncontrolled seizures
- Endocrine & Metabolic disorders, i.e. diabetes
- Genetic conditions
- Genito-urinary and gastrointesinal system disorders
- Heart conditions
- HIV/AIDS and other severe disorders of the immune system
- Musculoskeletal and connective tissue disorders, i.e. muscular dystrophy, JRA
- Sense organ disorders, i.e. hearing or vision loss

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 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

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:

- Patient's name
- Date of Birth
- Medi-Cal number (if available)
- Name, address and telephone number of parent/legal guardian
- Address and telephone number of the child
- Medical condition
- 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	**(510) 208-5970**	**California Children's Services (CCS)**
	(510) 267-3254 FAX	**Alameda County Public Health Department**
		1000 Broadway, Suite 500
		Oakland, CA 94607
	Web site	**http://www.dhcs.ca.gov/services/ccs**

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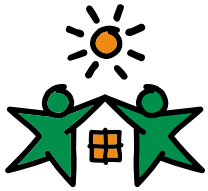
Genetically Handicapped Persons Program (GHPP)



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:

- Hemophilia and other genetic coagulation defects
- Cystic Fibrosis
- Sickle Cell Disease including Thalassemia
- Huntington's Disease
- Joseph's Disease
- Friedreich's Ataxia
- von Hippel-Lindau Disease
- Inborn Errors of Metabolism including disorders of amino-acid transport and metabolism such as Phenylketonuria (PKU)
- Disorders of carbohydrate transport and metabolism such as Galactosemia
- 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. There is no income limit, however, an applicant may be required to apply for Medi-Cal

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**
(916) 327-0470	**(messages may be left for call-back)**
(916) 440-5318 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**

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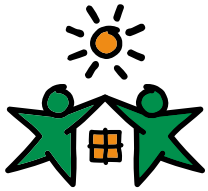
Newborn Hearing Screening Program (NHSP)



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:

- Parents of approximately 515,000 infants the opportunity to have their newborn babies screened for hearing loss at the time of the hospitalization for birth
- Tracking and monitoring of approximately 10,300 infants to assure that appropriate follow-up testing and diagnostic evaluations are completed
- Access to medical treatment and other appropriate educational and support services.
- 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 1000 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:

- **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.

- **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		
	(916) 322-5794	California NHSP Information/Brochures
	(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

Provider Contact Information

Alameda County Outpatient Hearing Screening Providers (CCS Approved)

Infant Screening and Hearing Services (ages 0 up to 21)	
(510) 204-3621	**Alta Bates Newborn Hearing Screening Program** (Newborns only) 2450 Ashby Avenue Berkeley, CA 94705
(510) 204-4599	**Alta Bates Hearing Assessment Services** (after failed hearing screen; birth up to 21) 2001 Dwight Way Berkeley, CA 94704
(510) 848-4800	**Center for Early Intervention on Deafness (CEID)** 1035 Grayson Street Berkeley, CA 94710
(510) 428-3344	**UCSF Benioff Children's Hospital Oakland Audiology Dept.** 744 - 52nd Street Oakland, CA 94609
(510) 537-4211	**Hearing Center of Castro Valley** 20126 Stanton Avenue, #205 Castro Valley, CA 94545
(510) 752-1889	**Kaiser Permanente Oakland Audiology Dept.** 3779 Piedmont Avenue, Ground Floor Oakland, CA 94611
Diagnostic Testing and Hearing Services only (ages 5 up to 21)	
(510) 832-4056	**Bay Area Hearing and Speech Center** 400 - 30th Street, Suite 101 Oakland, CA 94609-3548
(510) 895-4536 (510) 895-4518*	**Fairmont Hospital Audiology Clinic** 15400 Foothill Boulevard San Leandro, CA 94578 * Some limitation on diagnostic services for young children, so speak with audiologist before scheduling appointment.

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's Services (CCS)

RDs on some Special Care Center multidisciplinary teams
Provide comprehensive nutrition assessment and intervention.
Follow-up visits can by 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 dieticians in the community. Payment varies by individual dietician.

Women, Infants & Children (WIC) Program
See complete information about WIC nutrition services in this section of binder.

Contact Information

(510) 208-5970	**California Children's Services (CCS)**
(510) 618-2070	**CHDP Alameda County**
(510) 981-5300	**CHDP City of Berkeley**
(510) 618-6100	**Regional Center of the East Bay (RCEB)**
(510) 639-1000	**Medi-Cal**
(888) 942-9675	**WIC toll-free Information Line**

	American Dietetic Association - Find a Registered Dietician	
Web site	**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).

Services

What services are provided?

- Nutrition education and counseling at WIC clinics
- Screening and referrals to other health, welfare, and social services
- Supplemental nutritious foods and vouchers for selected foods
- Assistance with breastfeeding, including breast pumps
- 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 be nutritionally at-risk as determined by a health professional. The individual must be categorically eligible as a:

- Pregnant woman
- Woman post-partum to six months after delivery
- Woman six months to one year after pregnancy ends
- Infant (0 up to age 1)
- Child (1 up to age 5) at nutritional or medical risk

Contact Information

(888) WIC-WORKS/ (888) 942-9675 — **WIC California toll-free Information Line**
(510) 595-6400 — **WIC Alameda County**
(510) 981-5360 — **WIC City of Berkeley**
(510) 595-6470 — **Breastfeeding Help**

Addresses

- **WIC North Oakland Office**
  3600 Telegraph Ave., Oakland
- **WIC East Oakland/Eastmont Mall Office**
  7200 Bancroft Ave., 2nd floor, Suite #204, Oakland
- **WIC Fruitvale Office**
  3124 International Boulevard, Oakland
- **WIC Alameda Office**
  677 West Ranger Boulevard, Alameda
- **WIC Hayward Office**
  24085 Amador, Suite 100, Hayward
- **WIC Fremont Satellite Office/Fremont Resource Center**
  39155 Liberty Street, Suite #804, Fremont

Web site — **http://www.wicworks.ca.gov**

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Income Limit Tables (correct as of December 2015)

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	2015 Federal Poverty Level (100% FPL) for the 48 Contiguous States and District of Columbia (DC)
1	$ 11,770
2	$ 15,930
3	$ 20,090
4	$ 24,250
5	$ 28,410
6	$ 32,570
7	$ 36,730
Add'l	Add $4,160 for each additional person in the family.
Source: http://aspe.hhs.gov/poverty/15poverty.cfm	

Medi-Cal

Family Size	Children 0 up to age 19 Annual Income Not Over 250% FPL
1	$ 29,425
2 *	$ 39,825
3	$ 50,225
4	$ 60,625
5	$ 71,025
6	$ 81,425
7	$ 91,825
* 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	$ 23,540	$ 1,961
2	$ 31,860	$ 2,655
3	$ 40,180	$ 3,348
4	$ 48,500	$ 4,042
5	$ 56,820	$ 4,735
6	$ 65,140	$ 5,428
7	$ 73,460	$ 6,122

Kaiser Permanente Cares for Kids / Child Health Plan
Subject to change

Family Size parent + child	$0 Monthly Premium per child * Annual Income before taxes	$10 Monthly Premium per child * Annual Income before taxes	$20 Monthly Premium per child * Annual Income before taxes
1	$ 0 to $ 16,105	$ 16,106 to $ 23,340	$ 23,341 to $ 35,010
2	$ 0 to $ 21,707	$ 21,708 to $ 31,460	$ 31,461 to $ 47,190
3	$ 0 to $ 27,310	$ 27,311 to $ 39,580	$ 39,581 to $ 59,370
4	$ 0 to $ 32,913	$ 31,914 to $ 47,700	$ 47,701 to $ 71,550
5	$ 0 to $ 38,516	$ 38,517 to $ 55,820	$ 55,821 to $ 83,730
6	$ 0 to $ 44,119	$ 44,120 to $ 63,940	$ 63,941 to $ 95,910
7	$ 0 to $ 49,721	$ 49,722 to $ 72,060	$ 72,061 to $ 108,090
* 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			

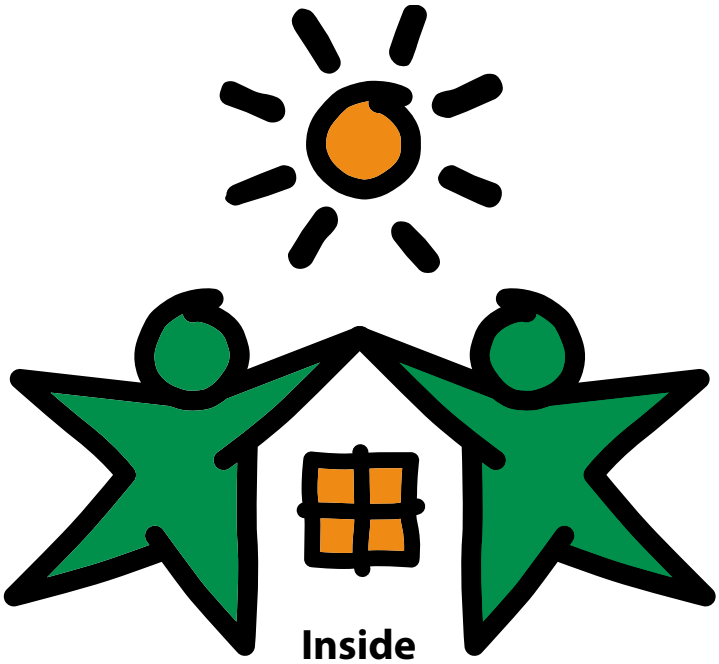
Medi-Cal Access Program (MCAP, formerly Access for Infants and Mothers)

Family Size	Monthly Household Income (Modified Adjusted Gross Income after MCAP Deductions)	Total Cost of MCAP Coverage (1.5% of Adjusted Annual Household Income)
2 *	$ 2,829 to $ 4,276	$ 509 to $ 770
3	$ 3,567 to $ 5,392	$ 642 to $ 971
4	$ 4,306 to $ 6,509	$ 775 to $ 1,172
5	$ 5,044 to $ 7,625	$ 908 to $ 1,373
6	$ 5,783 to $ 8,741	$ 1,041 to $ 1,574
7	$ 6,521 to $ 9,857	$ 1,174 to $ 1,775
Each Add'l	Add $ 740 to $ 1,118	Add $ 133 to $ 201
* 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 Povery Level					
Family Size	Annual	Monthly	2X Monthly	Bi-Weekly	Weekly
1	$ 21,775	$ 1,815	$ 908	$ 838	$ 419
2	$ 29,471	$ 2,456	$ 1,228	$ 1,134	$ 567
3	$ 37,167	$ 3,098	$ 1,549	$ 1,430	$ 715
4	$ 44,863	$ 3,739	$ 1,870	$ 1,726	$ 863
5	$ 52,559	$ 4,380	$ 2,190	$ 2,022	$ 1,011
6	$ 60,255	$ 5,022	$ 2,511	$ 2,318	$ 1,159
7	$ 67,951	$ 5,663	$ 2,832	$ 2,614	$ 1,307
Add'l	Add $ 7,696	Add $ 642	Add $ 321	Add $ 296	Add $ 148
Source: http://www.cdph.ca.gov/programs/wicworks/pages/wiceligibilityassessment03.aspx					

Mental Health Services



- Mental Health Services for Children Overview
- Alameda County Behavioral Health Care Services (BHCS)
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - Medi-Cal
  - Educationally Related Mental Health Services - Formerly AB 3632
  - Adolescent Alcohol / Drug Treatment
  - Transition Aged Youth (TAY) System of Care
- EPSDT Referrals - Early Childhood Mental Health & Parenting Services

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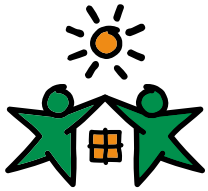
Mental Health Services for Children



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 friends • 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, attachment, sleeping and feeding. • May be indicated by excessive crying, anxiety and fearfulness, or withdrawn behavior. • May be related to exposure to trauma

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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Alameda County Behavioral Health Care Services (BHCS)

Alameda County Behavioral Health Care Services (BHCS) is the lead agency providing coordination of mental health treatment in Alameda County. Alameda County behavioral health referrals and services are obtained by calling their ACCESS 24-hour Hotline.

Alameda County BHCS Child and Youth Services offers programs that enable children with mental health needs, including those with Serious Emotional Disorders (SED), to access treatment and support.

Children served

Services are primarily provided for children on Medi-Cal or who are medically indigent. The populations served include:

- Young children and youth in the community who have mental health disorders
- Children receiving special education services who have been referred by the schools to receive mental health services under Educationally Related Mental Health Services
- Children in psychiatric inpatient facilities, and
- Dependents of the juvenile court with mental health needs.

Providers

Alameda County BHCS operates or funds eight children's outpatient mental health programs:

- Alameda Children's Outpatient Services (Alameda)
- Asian Community Mental Health (Oakland)
- Eden Children's Outpatient Services (San Leandro)
- La Clinica Casa Del Sol (Oakland)
- UCSF Benioff Children's Hospital Oakland Outpatient Services (Oakland)
- Tri-City Children's Outpatient Services (Fremont)
- Valley Children's Outpatient Services (Pleasanton)
- West Oakland Children's Services (West Oakland)

Referrals

A full list of providers can be found online at www.acbhcs.org/docs/ProviderList.pdf

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

(800) 491-9099	**ACCESS/Alameda County Behavioral Health Care Services 24-Hour Hotline**
Website	**www.acbhcs.org**

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - Medi-Cal
EPSDT is an entitlement to health and mental health services for children, 0 up to age 21, who are Medi-Cal eligible. In the mental health arena, EPSDT guarantees Medi-Cal eligible children and youth access to 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.

Alameda County BHCS recently expanded EPSDT, increasing the amount of services billable under EPSDT and expanding the number of agencies in the County able to provide these services. The following target populations now have increased mental health services under EPSDT:

- children birth to five
- children in foster care
- children with dual diagnosis of substance use and mental illness
- children receiving school-based services.

Agencies utilizing EPSDT funding are generally able to take direct referrals from primary care providers of children with full-scope Medi-Cal. You can call ACCESS to get listings of participating programs.

Referrals Referrals for EPSDT mental health services can be made through ACCESS or by calling the agency directly. See the included EPSDT Interagency Referral Guide for mental health agencies serving children 0-5 under EPSDT.

Contact Information

(800) 491-9099	**ACCESS / Alameda County Behavioral Health Care Services 24-Hour Hotline**

Mental Health Services Through Medi-Cal Managed Care Plans

Referrals

Alameda Alliance for Health Members
Beacon Health Strategies provides mental health benefits for children who:

1) **Are Alameda Alliance for Health members**
2) **Have a mild to moderate mental health condition**
3) **Have a suspected diagnosis of Autism**

Providers may utilize a screening tool developed by Beacon and ACCESS to determine where children should be receiving services. If the screening tool indicates a mild to moderate mental health condition, the child should be referred to Beacon Health Strategies. Children with mental health conditions classified as moderate to severe will be referred to services from ACCESS.

Anthem Blue Cross Members
Anthem Blue Cross requires prior authorization for mental/behavioral health services. ACCESS still covers mental health conditions classified as moderate to severe.

Contact Information

(855) 856-0577	**Beacon Health Strategies Member/Provider Services**
(866) 422-3413	**Beacon Health Strategies Fax**
(800) 407-4627	**Anthem Blue Cross Member/Provider Services**

Special Education Mental Health - Educationally Related Mental Health Services (ERMHS)

This program provides mental health services to students in an interagency model through the school district. This program is available to students who are receiving special education services and have been determined to be in need of mental health treatment in order to benefit from their education.

Referrals

Referrals to Alameda County Behavioral Health Care Services for evaluation and determination of eligibility for mental health services under ERMHS can be initiated by the student's local school district special education Individualized Education Plan (IEP) team.

Contact Information

(800) 491-9099	**ACCESS / Alameda County Behavioral Health Care Services 24-Hour Hotline**

Call your…	**Child's Local School District's Dept. of Special Education:**
(510) 670-7736	**Alameda County Office of Education**
(510) 337-7075	**Alameda**
(510) 559-6536	**Albany**
(510) 644-8913	**Berkeley**
(510) 537-3000 x1200	**Castro Valley**
(925) 828-2551 x8031	**Dublin**
(510) 601-4907	**Emeryville**
(510) 659-2569	**Fremont**
(510) 784-2611	**Hayward**
(925) 606-3225	**Livermore Valley**
(510) 471-1100 x62616	**New Haven (Union City)**
(510) 818-4209	**Newark**
(510) 879-8100	**Oakland**
(510) 594-2893	**Piedmont**
(925) 426-4293	**Pleasanton**
(510) 667-3507	**San Leandro**
(510) 317-4761	**San Lorenzo**

Call your…	**Special Education Local Planning Area (SELPA) Office:**
(510) 525-9800	**SELPA - Alameda/Albany/Berkeley/Emeryville/Piedmont**
(510) 879-8100	**SELPA - Oakland**
(510) 537-3335x1220	**SELPA - Castro Valley/Hayward/San Leandro/San Lorenzo**
(510) 659-2569	**SELPA - New Haven/Newark/Fremont**
(925) 426-9144	**SELPA - Dublin/Livermore/Sunol Glen/Mountain House Elementary/Pleasanton**

Adolescent Alcohol / Drug Treatment

Services are provided to youth between the ages of 12–18. Treatment services include assessment; treatment planning; individual, group, and family counseling; social and recreational activities. The following community based organizations are contracted with Alameda County BHCS to provide alcohol and drug treatment to adolescents:

- Asian Community Mental Health Center
- Community Health for Asian Americans (CHAA)
- City of Fremont Youth and Family Services
- New Bridge ASPIRE School Program
- Project Eden
- Thunder Road Adolescent Treatment
- AXIS Community Health Center

Contact Information

(800) 491-9099 — **ACCESS / Alameda County Behavioral Health Care Services 24-Hour Hotline**

Transition Aged Youth (TAY) System of Care

The Transition Age Youth System of Care exists to improve the services and outcomes for youth, aged sixteen through twenty-four who are experiencing mental illness.

The TAY System of Care primarily serves youth aged 16–24 who are Seriously Emotionally Disturbed (SED) or Seriously Mentally Ill (SMI). As a result of the mental health disability the young person has substantial impairment in self-care, school functioning, family relationships, or in their ability to function in the community. The TAY System of Care assists eligible youth to make successful and seamless transitions towards self-sufficiency and independent living

Referrals

Clinicians may make referrals to the Transition Age Treatment (TAT) team using the **TAT Referral Form (Section H)**. This multidisciplinary team meets weekly to review cases.

Contact Information

(800) 491-9099 — **ACCESS / Alameda County Behavioral Health Care Services 24-Hour Hotline**

(510) 567-8100 — **TAY Services - Radawn Alcorn, Interim Director ralcorn@acbhcs.org**

Early Childhood Mental Health and Parenting Services Inter-Agency Referral Guide

EPSDT PROGRAMS

For Families with Children Ages 0-5 with Full-Scope Medi-Cal

2015

This guide was updated with the support of First 5 Alameda County

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INTRODUCTION

To learn and grow, children must be emotionally secure and physically healthy. Mental health is closely tied to the relationships a child has with parents and significant caregivers. As an infant develops trust and attachment, the foundation for lifelong success in relationships and school is established. Children learn how to effectively express emotions, make friends, and explore the world around them through these relationships. A nurturing, caring relationship provides a "secure base" from which a child can begin exploring the world. That relationship can go astray for a variety of reasons. Studies have shown that mental health services for young children and their families can facilitate or repair the relationship and can have a positive, lasting impact.

This manual predominately focuses on mental health services for children 0-5 that can be billed through EPSDT. EPSDT (Early Periodic Screening, Diagnosis, and Treatment) is a Medi-Cal entitlement for children 0-21 years old that is designed to provide mental health services that can correct or ameliorate mental health problems and is available to children covered by full-scope Medi-Cal (Medi-Cal coverage without restrictions). Additionally, If an agency has other funding sources for treatment services, we have encouraged them to include that information here.

If you have a client in need of these services, please refer to one of the agencies accepting EXTERNAL referrals.

This manual will be updated on an as-needed basis. The current version was updated with the support of First 5 Alameda County.

For questions or comments, please email:
Margie Gutierrez-Padilla
Early Connections 0-5 System of Care Coordinator
Alameda County Behavioral Health Care Services
MPadilla@acbhcs.org

We hope you find this referral guide useful in your search for an EPSDT-funded early childhood mental health program.

TABLE OF CONTENTS

Please review the program descriptions carefully, as some agencies in this guide do not accept external referrals for early childhood mental health services.

A BETTER WAY

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
3200 Adeline Street Berkeley, CA 94703	Mental Health Intake Leonora Padilla (510) 601-0203 ext. 325	English Mien Spanish Vietnamese
Population Served:	Foster/adopt children/youth, ages 0-21 yrs.	
Geographic Area Served:	Berkeley, Oakland, Hayward and vicinities	

Services:

	Individual therapy	X	Developmental Guidance	X
	Family therapy	X	Resource and Referral	X
	Group therapy	X		
	Infant/child parent dyadic therapy	X	**Service Locations:**	
	Case management		In the home	X
	Supervised visitation	X	In the office	X
	Medication support		At childcare	
	Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:
A Better Way offers permanency-informed behavioral health services to children, youth and families involved in, or at risk for becoming involved in the Foster Care system. A Better Way has programs specifically designed for children and youth across the dependency and permanency spectrum. A Better Way has expertise in providing Early Childhood Mental Health Services including collaborative, relationship-based, dyadic and family services. A Better Way also utilizes Evidence Based Mental Health and Parent training practices when indicated - including PCIT, Incredible Years, Trauma Focused-CBT & CBT

Referrals accepted from:
☑ Internal ☑ External (Community wide)

For the services checked above, do you accept any clients who do not have full-scope Medi-cal?
No.
If yes, please indicate what funding you will accept and any limitations to that funding source
__X__ Victims of Crime (VOC)- Must be Alameda ACCESS Referral

__X__ Private Pay (minimum rate of $150.00 an hour)

__X__ Grants and Contracts (Parent classes and trainings through Title IV-E funding.)

_____ Private Health Insurance

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
THE EARLY CHILDHOOD CONSULTATION AND TREATMENT PROGRAM (ECCTP)

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
500 Davis Street, Suite 120 San Leandro, CA 94577	Deb Yates, LCSW (510) 481-4203	English Spanish Arabic Interpreters Available

Population Served:	0-6 yrs.
Geographic Area Served:	Alameda, Berkeley, Emeryville, Fremont, Hayward, Oakland, San Leandro and San Lorenzo. May accept referrals from other areas within Alameda County depending on staff availability.

Services:

Individual therapy	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy	X		
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	X
Supervised visitation		In the office	X
Medication support		At childcare	X
Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:
This program is a mental health service delivery program that provides mental health consultation to childcare, as well as direct therapy services in childcare, in the home and in the clinic. Infant and early childhood/parent therapy is focused on behavioral, social-emotional and/or developmental needs of children in the context of their relationship with primary caretakers. Accepts children up to age 6 which means they can be seen until 7 years of age. A limited number of children without any insurance are served (referred to as medically indigent).

Referrals accepted from:
☑ Internal ☑ External (Community wide)

<u>For the services checked above</u>, do you accept any clients who do not have full-scope Medi-cal?
Yes, very limited number of children who are medically indigent.

If yes, please indicate what funding you will accept and any limitations to that funding source
_____ Victims of Crime (VOC)

_____ Private Pay

_____ Grants and Contracts

_____ Private Health Insurance

ALAMEDA FAMILY SERVICES

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
2325 Clement Ave. Alameda, CA 94501	Tel: (510) 629-6324 Fax: (510) 865-1930	Spanish Urdu/Hindi Vietnamese Subject to change each training year
Population Served:	0-6 yrs., Children, Youth and Families 6-18, adults 21+ and couples	
Geographic Area Served:	Alameda County	

Services:

Individual therapy	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy	X		
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	X
Supervised visitation		In the office	X
Medication support		At childcare	X
Developmental & Socio Emotional Assessment		At other community locations	

Program Description:
This program is a mental health service delivery program that provides mental health consultation to childcare, as well as direct therapy services in childcare, in the home and in the clinic. Infant and early childhood/parent therapy is focused on behavioral, social-emotional and/or developmental needs of children in the context of their relationship with primary caretakers. Accepts children up to age 5 which means they can be seen until 7 years of age.
Other relevant agency services include Anger Management groups, Survival Skills for Parents of Teens, Drug and Alcohol Treatment, School-Based Health Services and mental health services for families with children birth-18, individual adults and couples.

Referrals accepted from:
☑ Internal ☑ External (Community wide)

<u>For the services checked above</u>, do you accept any clients who do not have full-scope Medi-cal? Yes.

If yes, please indicate what funding you will accept and any limitations to that funding source
_____ Victims of Crime (VOC)

__X__ Private Pay ($20-$90)

__X__ Grants and Contracts (First 5 Every Child Counts and Early Head Start)

_____ Private Health Insurance

ASIAN COMMUNITY MENTAL HEALTH SERVICES
READY, SET, GO! EARLY CHILD INTERVENTION PROGRAM

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
310 8th Street, Suite 201 Oakland, CA 94607	Amy Szeto, LCSW (510) 869-6075	Chinese (Cantonese, Mandarin) Cambodian Vietnamese Mien Interpreters available: Burmese Mongolian
Population Served:	0-6 yrs.	
Geographic Area Served:	Oakland, Alameda, Hayward, San Leandro, San Lorenzo, Fremont & Richmond	

Services:

	Individual therapy	X	Developmental Guidance	X
	Family therapy	X	Resource and Referral	X
	Group therapy	X		
	Infant/child parent dyadic therapy	X	**Service Locations:**	
	Case management	X	In the home	X
	Supervised visitation		In the office	X
	Medication support		At childcare	X
	Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:
This program is a mental health service delivery program that provides mental health consultation to childcare, as well as direct therapy services in childcare, in the home and in the clinic. Infant and early childhood/parent therapy is focused on behavioral, social emotional and/or developmental needs of children in the context of their relationship with primary caretakers. Accepts children up to age 6 which means they can be seen until 7 years of age. A limited number of children without any insurance are served (referred to as medically indigent).

Referrals accepted from:
☑ Internal ☑ External (Community wide)

For the services checked above, do you accept any clients who do not have full-scope Medi-cal? Yes.

If yes, please indicate what funding you will accept and any limitations to that funding source
__X__ Victims of Crime (VOC)

_____ Private Pay

__X__ Grants and Contracts (please list and indicate who is served by the funding).
Currently, we have limited funding from Every Child Counts to provide mental health services to children (0-5) and families in childcare; Safe Passages; Safe Start; and Violence Prevention funds from the Governor's Office of Emergency.

_____ Private Health Insurance

BRIGHTER BEGINNINGS

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
2648 International Blvd Oakland, CA 94601	Intake Coordinator (510)903-7513 (510)437-8953 (Fax)	English Spanish
Population Served:	Children-Youth ages 0 - 21. Adults on CalWorks.	
Geographic Area Served:	Alameda County	

Services:

	Individual therapy	X	Developmental Guidance	X
	Family therapy	X	Resource and Referral	X
	Group therapy			
	Infant/child parent dyadic therapy	X	**Service Locations:**	
	Case management	X	In the home	X
	Supervised visitation		In the office	X
	Medication support		At childcare	X
	Developmental & Socio Emotional Assessment		At other community locations	X

Program Description:
Our Bright Futures program provides outpatient mental health services to all children 0-21 years of age. Early childhood mental health therapy for children 0-6 provided. Currently focus on children ages 0-21. Through CalWorks, therapeutic services for adults can be provided.

Referrals accepted from:
☐ Internal ☑ External (Community wide)

<u>For the services checked above</u>, do you accept any clients who do not have full-scope Medi-cal?

We can serve children and adults on Alameda County CalWorks.

If yes, please indicate what funding you will accept and any limitations to that funding source
_____ Victims of Crime (VOC)

_____ Private Pay

__X__ Grants and Contracts (Every Child Counts, AFLP, Cal Learn, Early Head Start) (For case management and help with development, NOT mental health therapy.)

_____ Private Health Insurance

CITY OF FREMONT, YOUTH AND FAMILY SERVICES (YFS) INFANT-TODDLER PROGRAM

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
Youth and Family Services 39155 Liberty St, Ste. E500 P.O. Box 5006 Fremont, CA 94537-5006	Reva Srinivasan, Ph.D (510) 574-2124	Spanish Hindi English Call for other languages
Population Served:	Children 0 to 5 years of age (through the 5th birthday)	
Geographic Area Served:	Fremont, Newark and Union City	

Services:

Individual therapy	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy			
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	X
Supervised visitation		In the office	X
Medication support		At childcare	
Developmental & Socio Emotional Assessment	X	At other community locations	

Program Description:
This program provides relationship-based therapy and case management to families facing various stressors. Typical concerns might be about the child (such as tantrums, eating or sleeping difficulties, aggressive behavior, distressed at separation), the whole family (such as reactions to divorce, death, job loss) or a parent (such as need for support because of depression, health problems, anxiety or trauma).

Referrals accepted from:
☐ Internal ☑ External (Community wide)

For the services checked above, do you accept any clients who do not have full-scope Medi-cal?
Yes.

If yes, please indicate what funding you will accept and any limitations to that funding source
_____ Victims of Crime (VOC)

__X__ Private Pay (Sliding fee scale $10-$135)

_____ Grants and Contracts

_____ Private Health Insurance

COMMUNITY ASSOCIATION FOR PRESCHOOL EDUCATION (CAPE)

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
3095 Independence Drive Building B, Suite A Livermore, CA 94551	(925) 443-3434 ext. 108 Fax: (925)443-0310	English Spanish

Population Served:	Children ages 0-5, children with special needs, pregnant women.
Geographic Area Served:	Tri-Valley (Livermore, Dublin, Pleasanton)

Services:

Individual therapy	X	Developmental Guidance	
Family therapy	X	Resource and Referral	
Group therapy			
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	
Supervised visitation		In the office	X
Medication support		At childcare	X
Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:
CAPE is a Head Start and Early Head Start agency operating in the Tri-Valley. CAPE offers full day childcare, preschool, disability services, health and nutrition services, and mental health services. Through regularly scheduled mental health consultation meetings a systematic approach is used to address mental health concerns including staff and parents receiving special help to address children with atypical behavior. Other community mental health resources, as well as CAPE's Mental Health Services Program which is funded through a provider contract with Alameda County Behavioral Health Care Services, are used as needed through referrals and formal collaborations.

Referrals accepted from:
☐ Internal ☑ External (Community wide)

<u>For the services checked above,</u> do you accept any clients who do not have full-scope Medi-cal?
No

If yes, please indicate what funding you will accept and any limitations to that funding source
_____Victims of Crime (VOC)

_____Private Pay

_____Grants and Contracts

_____Private Health Insurance

EAST BAY AGENCY FOR CHILDREN
THERAPEUTIC NURSERY SCHOOL

Main Office:	**Referrals/Intakes:**	**Language:**
6117 Martin Luther King Way Oakland, CA 94609	Nancy Wallin (510) 655-4896	English Spanish
Population Served:	**Children 2 ½ - 6 yrs.**	
Geographic Area Served:	**Alameda County**	

Services:

Individual therapy	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy	X		
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	
Supervised visitation		In the office	X
Medication support	X	At childcare	
Developmental & Socio Emotional Assessment	X	At other community locations	

Program Description:
EBAC's Therapeutic Nursery School (TNS) in Oakland provides early childhood education and comprehensive mental health services for children ages 2 ½ through 6 years old who have behavioral, emotional and or learning challenges.

Referrals accepted from:
☐ Internal ☑ External (Community wide)

<u>For the services checked above</u>, do you accept any clients who do not have full-scope Medi-cal?
No.

If yes, please indicate what funding you will accept and any limitations to that funding source

_____ Victims of Crime (VOC)

_____ Private Pay

_____ Grants and Contracts

_____ Private Health Insurance

FAMILY PATHS
EARLY CHILDHOOD MENTAL HEALTH TREATMENT PROGRAM

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
1727 Martin Luther King Jr. Way, #109 Oakland, CA 94612 (510) 893-9230	Intake and 24 Hour Hotline (510) 893-5444 || (800) 829-3777	English Spanish Japanese
Population Served:	0-6 yrs.	
Geographic Area Served:	Alameda County	

Services:				
	Individual therapy	X	Developmental Guidance	X
	Family therapy	X	Resource and Referral	X
	Group therapy			
	Infant/child parent dyadic therapy	X	**Service Locations:**	
	Case management	X	In the home	X
	Supervised visitation		In the office	X
	Medication support		At childcare	
	Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:
Provides relationship-based mental health services to infants, toddlers, and preschoolers who are experiencing mental health problems due to adverse life circumstances and traumatic stress. Clinicians work with children and their caregivers together in child-parent therapy to promote safety and security in their relationships in order to meet children's developmental, emotional, and behavioral needs. Support and linkage to community resources are provided to further families' stability and well-being. Services may be continued past age 6 when needed. Other relevant agency services include parenting education classes, 24 hour Parent Support Hotline, and mental health services for families with children 6-21 years old.

Referrals accepted from:
☑ Internal ☑ External (Community wide)

Parent Support Hotline, Access, CFS, Preschools, Public Health Nursing, Community Agencies, Family Members

For the services checked above, do you accept any clients who do not have full-scope Medi-cal? *Yes*
If yes, please indicate what funding you will accept and any limitations to that funding source

__X__ Victims of Crime (VOC)

_____ Private Pay

__X__ Grants and Contracts (Small amount of Measure Y funding to serve Oakland residents who have been exposed to family violence and who also do not have Medi-Cal.)

_____ Private Health Insurance

JEWISH FAMILY AND CHILDREN'S SERVICES OF THE EAST BAY
FIRST STEPS EARLY CHILDHOOD MENTAL HEALTH PROGRAM

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
2484 Shattuck Ave, Suite 210 Berkeley, CA 94704	Celina Ramirez (Spanish) (510) 636-4026 Valerie Rosenfield (English) (510) 704-7480 ext. 700	English Spanish Bosnian Russian Hebrew Farsi/Dhari

Population Served:	0-6 years in home; 7-21 years in office only
Geographic Area Served:	Alameda, Albany, Berkeley, Emeryville, Oakland, San Leandro, San Lorenzo, Hayward, Pleasanton, Dublin, Livermore, Sunol

Services:

Individual play	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy	X		
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	X
Supervised visitation		In the office	X
Medication support		At childcare	X
Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:
This program provides comprehensive, relationship based therapy, consultation, and case management services. Services are focused on behavioral, social-emotional and or developmental needs of children 0-6 and their caregivers.

Referrals accepted from:
☐ Internal ☑ External (Community wide)

For the services checked above, do you accept any clients who do not have full-scope Medi-cal?
Yes.

If yes, please indicate what funding you will accept and any limitations to that funding source
__X__ Victims of Crime (VOC) (Office Only)

__X__ Private Pay ($45- $140 Office Only)

__X__ Grants and Contracts (OFCY & Measure Y. First 5 at Pre-school site).

__X__ Private Health Insurance (Office Only)

KIDANGO
CHILD AND FAMILY SUPPORT PROGRAM

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
43100 Isle Royal Street Fremont, CA 94538	Intake Coordinator (510) 897-6938 (510) 897-6909 (Fax)	English Spanish
Population Served:	0 to 5 yrs.	
Geographic Area Served:	Hayward, Oakland, San Leandro, San Lorenzo, Union City, Fremont, Newark, Pleasanton, Dublin, Livermore, Sunol, Berkeley, Alameda, Castro Valley, Emeryville	

Services:

Individual therapy	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy	X		
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	X
Supervised visitation		In the office	X
Medication support		At childcare	X
Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:
This program provides mental health services in childcare programs as well as in the caregivers' home and community.

Referrals accepted from:
☑ Internal ☑ External (Community wide)

Children attending Kidango Child Development sites are eligible as are other qualifying children from the general community.

For the services checked above, do you accept any clients who do not have full-scope Medi-cal? Yes.

If yes, please indicate what funding you will accept and any limitations to that funding source

_____ Victims of Crime (VOC)

_____ Private Pay

__X__ Grants and Contracts (CAPS 0-5 and their families in Spanish and English).

_____ Private Health Insurance

LA CLINICA DE LA RAZA, CASA DEL SOL

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
1501 Fruitvale Ave. Oakland, CA 94601	Intake Coordinator (510) 535-6200	English Spanish (Focus on mono-and bilingual children families.)
Population Served:	Children 0-18 yrs, Adults 18+	
Geographic Area Served:	Alameda County	

Services:

Individual therapy	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy	X		
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	X
Supervised visitation		In the office	X
Medication support	X	At childcare	
Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:

Casa del Sol's Infant Mental Health Program focuses on serving Spanish speaking families where the child has a mental health condition. This program provides relationship-based therapy and case management for children who have a mental health condition. Assessments and treatment use strength based and culturally focused approaches. Typical concerns include: attachment problems, PTSD, depression, anxiety, oppositional behaviors, tantrums, eating or sleeping problems, elimination disorders, and/or aggressive behaviors. In addition to individual, dyadic, family therapy, and case management services for the children/families, additional services are available to family members. Additional services that are provided in Spanish include: parent education/support groups, adult grief group, crisis stabilization services, domestic violence groups for women, child abuse prevention services, and groups for children who have been exposed to domestic violence. All Staff members are bilingual Spanish/English.

Referrals accepted from:

☑ Internal ☑ External (Community wide)

<u>For the services checked above</u>, do you accept any clients who do not have full-scope Medi-cal?

Yes. Services are provided to uninsured children in crisis 0-18 years old.

If yes, please indicate what funding you will accept and any limitations to that funding source

_____ Victims of Crime (VOC)

_____ Private Pay

_____ Grants and Contracts

_____ Private Health Insurance

LA FAMILIA COUNSELING SERVICE
OUTPATIENT SERVICES

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
26081 Mocine Avenue Hayward, CA 94544	Intake Coordinator (510)881-5921	English Spanish
Population Served:	0-18 yrs, 18+	
Geographic Area Served:	Alameda County	

Services:

Individual therapy	X	Developmental Guidance	
Family therapy		Resource and Referral	X
Group therapy			
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management		In the home	X
Supervised visitation		In the office	X
Medication support		At childcare	
Developmental & Socio Emotional Assessment	X	At other community locations	

Program Description:
This program provides services to infants, children, and families. Infant and early childhood/parent therapy focusing on culturally competent behavioral, social-emotional and or developmental needs of children 0-6.

Referrals accepted from:
☑ Internal ☑ External (Community wide)

Referrals received within agency, from community agencies, and school sites.

<u>For the services checked above</u>, do you accept any clients who do not have full-scope Medi-cal?
No. 0-18 years old need Medi-cal. 18+ sliding scale and free services available.

If yes, please indicate what funding you will accept and any limitations to that funding source
____ Victims of Crime (VOC)

____ Private Pay

____ Grants and Contracts (please list and indicate who is served by the funding).

____ Private Health Insurance

PORTIA BELL HUME BEHAVIORAL HEALTH & TRAINING CENTER (THE HUME CENTER) EARLY CHILDHOOD MENTAL HEALTH SERVICES

Main Office:	**Referrals/Intakes:**	**Language Capacity:**			
39645 Paseo Padre Pky	Intake Coordinator	English	Spanish	French	Mandarin
Suite 2100	(510)745-9151	Cantonese	Farsi	Hindi	Punjabi
Fremont, CA 94538	(510)745-9152 (Fax)	Thai	Vietnamese	Urdu	Arabic
Population Served:	Early Childhood Mental Health 0-6, Children and Youth 6-21 years & adults 21+				
Geographic Area Served:	Alameda County				

Services:

Individual therapy	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy	X		
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	X
Supervised visitation		In the office	X
Medication support	X	At childcare	X
Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:

The goal and aspirations of the program is to provide Prevention, Intervention, and Support to children and their families who are at risk or in the throes of social, emotional, behavioral or developmental difficulties. There are various signs that arise in infants and children that signal difficulties, and could benefit from our services. We also recognize that the parenting process can be frustrating, overwhelming, and bring about feelings of isolation. We believe that if these difficulties are addressed early, with support and compassion, suffering can be minimized in later life and there can be progress toward successful development and positive family relationships.

Referrals accepted from:

☑ Internal ☑ External (Community wide)

For the services checked above, do you accept any clients who do not have full-scope Medi-cal? *Yes.*

If yes, please indicate what funding you will accept and any limitations to that funding source

__X__ Victims of Crime (VOC)

__X__ Private Pay (Minimum fee is $40 or 2% of net monthly income, whichever is higher)

__X__ Grants and Contracts (CalWorks; Prevention-Children, Families, and S. Asians; Limited Indigent Clients; California Children's Services)

_____ Private Health Insurance

THROUGH THE LOOKING GLASS

Main Office:	**Referrals/Intakes:**	**Language Capacity:**			
3075 Adeline Street	Intake Coordinator	English	Spanish	ASL	Japanese
Suite 120	Iliana Escobar	Portuguese	Farsi	German	Korean
Berkeley, CA 94703	(510) 848-1112 x8114	Turkish	Tagalog	Hindu	Cantonese
		Mandarin	Punjabi		

Population Served:	Children 0-18 yrs.
Geographic Area Served:	Alameda County

Services:

Individual therapy	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy			
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	X
Supervised visitation	X	In the office	X
Medication support		At childcare	X
Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:

This program specializes in serving children with developmental concerns and/or delays, behavioral, social emotional, or attachment concerns, possible disabilities (physical, cognitive, sensory) or significant medical issues (prematurity/medical fragility, birth defects, surgeries, failure to thrive, illness). The program also specializes in serving children whose parents/caretakers have disabilities (including physical, cognitive, sensory, and mental health/emotional) or significant medical issues. Based in the disability and Deaf communities, this program provides a unique specialized service with expertise regarding mental health, developmental, cultural and adaptation issues associated with infant/child and family disability and deafness.

Referrals accepted from:

☑ Internal ☑ External (Community wide)

Agency accepts children 0-18 who are Medi-Cal clients in Alameda County. Parameters of non-Medi-Cal clients depend upon grant availability. Please call to inquire about funding.

For the services checked above, do you accept any clients who do not have full-scope Medi-cal? *Yes.*

If yes, please indicate what funding you will accept and any limitations to that funding source

____ Victims of Crime (VOC)

_X_ Private Pay ($113-$120 hr.)

_X_ Grants and Contracts (Regional Center of the East Bay, City of Berkeley, Every Child Counts Alameda County, First 5 Contra Costa, Safe Passages, Foundation Grants.)

____ Private Health Insurance

TIBURCIO VASQUEZ HEALTH CENTER, INC
FAMILY SUPPORT SERVICES

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
22211 Foothill Blvd. Hayward, CA 94541	Kimberly Wheat (510) 471-5907 ext. 3784	Spanish English
Population Served:	0-6 yrs. Pregnant and parenting teens under the age of 21, school based children 0-21	
Geographic Area Served:	Hayward, Union City, Fremont, Newark, San Leandro, San Lorenzo, Castro Valley	

Services:

Individual therapy	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy	X		
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	X
Supervised visitation		In the office	X
Medication support	X	At childcare	X
Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:
This program provides strength based, culturally and linguistically responsive therapy case management and developmental guidance to the following populations; infants and children (0-5) and their caregivers/families (including caregiver-child dyadic attachment based therapy, play therapy, collateral sessions with family to support child), and pregnant and parenting teens/young adults and their children. School-based services in Hayward and San Lorenzo Unified School Districts.

Referrals accepted from:
☑ Internal ☑ External (Community wide)

For the services checked above, do you accept any clients who do not have full-scope Medi-cal?
Yes.

If yes, please indicate what funding you will accept and any limitations to that funding source

__X__ Victims of Crime (VOC)

_____ Private Pay

_____ Grants and Contracts

_____ Private Health Insurance

UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND
BEHAVIOR EMERGENCY RESPONSE TEAM (BERT)

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
747 52nd Street Oakland, CA 94607 CHRCO Emergency Department	Ask for the social worker on call (510) 428-3000	Interpreters available
Population Served:	Children under 12 years old or 5150 admissions	
Geographic Area Served:	Alameda County	

Services:

Individual therapy		Developmental Guidance	
Family therapy		Resource and Referral	X
Group therapy			
Infant/child parent dyadic therapy		**Service Locations:**	
Case management	X	In the home	
Supervised visitation		In the office	X
Medication support	X	At childcare	
Developmental & Socio Emotional Assessment	X	At other community locations	

Program Description:
24-hour crisis stabilization services within the Emergency Department at Children's Hospital for children under 12 years old.

Referrals accepted from:
☑ Internal ☑ External (Community wide)

Accepts referrals from Children's Hospital.

<u>For the services checked above</u>, do you accept any clients who do not have full-scope Medi-cal?
Yes.

If yes, please indicate what funding you will accept and any limitations to that funding source
_____ Victims of Crime (VOC)

__X__ Private Pay

_____ Grants and Contracts

__X__ Private Health Insurance

UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND
BEHAVIORAL PEDIATRICS CLINIC

Main Office: 645 4th Street Oakland, CA 94607	**Referrals/Intakes:** Intake Coordinator (510) 428-3441	**Language Capacity:** English Spanish Interpreters Available
Population Served:	3-12 yrs. Psychological testing and assessment available up to age 20	
Geographic Area Served:	Alameda County	

Services:

Individual therapy	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy	X		
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	X
Supervised visitation		In the office	X
Medication support		At childcare	X
Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:
This program provides multidisciplinary/team based assessment and treatment for children 3-12 years old with social/emotional behavioral disorders. Priority is given to children in foster care, kinship care, or at-risk for out-of-home placement.

Referrals accepted from:
☑ Internal ☑ External (Community wide)

<u>For the services checked above</u>, do you accept any clients who do not have full-scope Medi-cal?
No.

If yes, please indicate what funding you will accept and any limitations to that funding source
_____ Victims of Crime (VOC)

_____ Private Pay

_____ Grants and Contracts

_____ Private Health Insurance

UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND

COMPREHENSIVE PSYCHIATRIC CENTER: CHILD DEVELOPMENT CENTER SITE

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
5220 Claremont Avenue Oakland, CA 94618	Intake Coordinator (510) 428-8428	English Interpreters Available

Population Served:	Children up to the age of 18
Geographic Area Served:	Alameda County

Services:

Individual therapy		Developmental Guidance	X
Family therapy		Resource and Referral	X
Group therapy			
Infant/child parent dyadic therapy		**Service Locations:**	
Case management	X	In the home	
Supervised visitation		In the office	X
Medication support	X	At childcare	
Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:
This program provides medication assessment, treatment and management, case management, and coordination of care with other programs for children under 18 years old. Priority is given to children in foster care, kinship care, or at risk for out of home placement.

Referrals accepted from:
☑ Internal ☑ External (Community wide)

Accepts referrals from Children's Hospital.

For the services checked above, do you accept any clients who do not have full-scope Medi-cal?
Yes.

If yes, please indicate what funding you will accept and any limitations to that funding source
_____ Victims of Crime (VOC)

__X__ Private Pay

_____ Grants and Contracts

__X__ Private Health Insurance

UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND
EARLY CHILDHOOD MENTAL HEALTH PROGRAM

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
638 3rd Street Oakland, CA 94608	Intake Coordinator (510) 428-3407	English Arabic Spanish Tagalog Visayan
Population Served:	Children 0-6 yrs.	
Geographic Area Served:	Alameda County	

Services:

Individual therapy	X	Developmental Guidance	X
Family therapy	X	Resource and Referral	X
Group therapy	X		
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management	X	In the home	X
Supervised visitation	X	In the office	X
Medication support		At childcare	X
Developmental & Socio Emotional Assessment	X	At other community locations	X

Program Description:

This program provides assessment and mental health treatment services to children and their caretakers with a specialized focus on the birth to three year-old population (though children are accepted up to age 5). Services are provided by a multidisciplinary team that includes mental health and developmental specialists. The program specializes in serving children and families where medical, developmental and social emotional concerns may co-exist. In addition to individual treatment services, group programs are offered for families in the child welfare system working on reunification, families struggling with substance use, and previously incarcerated parents. Other services offered by the program on grant funding include developmental playgroups and parent support groups for Spanish Speaking families who have young children with disabilities.

Referrals accepted from:

☑ Internal ☑ External (Community wide)

Internal referrals only for FIRST program. Accepts referrals from Children's Hospital, community clinics and pediatric providers, Public Health Dept, Social Services, Early Care and Education programs and other community based agencies.

For the services checked above, do you accept any clients who do not have full-scope Medi-cal? Yes.

If yes, please indicate what funding you will accept and any limitations to that funding source

_____ Victims of Crime (VOC)

_____ Private Pay

__X__ Grants and Contracts

_____ Private Health Insurance

WestCoast Children's Clinic

Main Office:	**Referrals/Intakes:**	**Language Capacity:**
3301 E. 12th Street Ste. 259 Oakland, California 94601	Intake Coordinator (510) 269-9030 Fax: (510) 269-9031	Cantonese Spanish Tagalog Russian

Population Served:	Children 3-22 yrs.
Geographical Area Served:	Alameda County Clients up to 1-2 hours from Oakland

Services:

Individual therapy	X	Developmental Guidance	
Family therapy	X	Resource and Referral	
Group therapy	X		
Infant/child parent dyadic therapy	X	**Service Locations:**	
Case management		In the home	X
Supervised visitation		In the office	X
Medication support		At childcare	
Developmental & Socio Emotional Assessment	X	At other community locations	

Program Description:

Private, non-profit child therapy agency with EPSDT contracts (primarily serving Alameda County). We serve children and families in foster care and children/families with full-scope Medi-cal.

Programs include: outpatient community or clinic based therapy (ages 3-22), psychological assessment (ages 3-22) partial to full batteries with a therapeutic, systemic, collaborative model. Transitional age youth programs include: Foster Youth Development (ages 14-17); C Change (for sexually exploited minors); Catch 21(for transitional age youth coming out of higher level care); STAT (screening/assessment for children/youth entering foster care); Project 1959 (transitional services for youth with high placement utilization).

Our model is integrative (psycho-dynamic, dyadic, systemic, culturally linked), we have experience in models of attachment, trauma, and long-term therapy, and collaborative psychological assessment. We are also a training program for pre-doctoral interns and post-doctoral residents. We have a multi-disciplinary staff (no psychiatric services).

Referrals accepted from:

☑ Internal ☑ External (Community wide)

For the services checked above, do you accept any clients who do not have full-scope Medi-cal?

Not at this time.

If yes, please indicate what funding you will accept and any limitations to that funding source

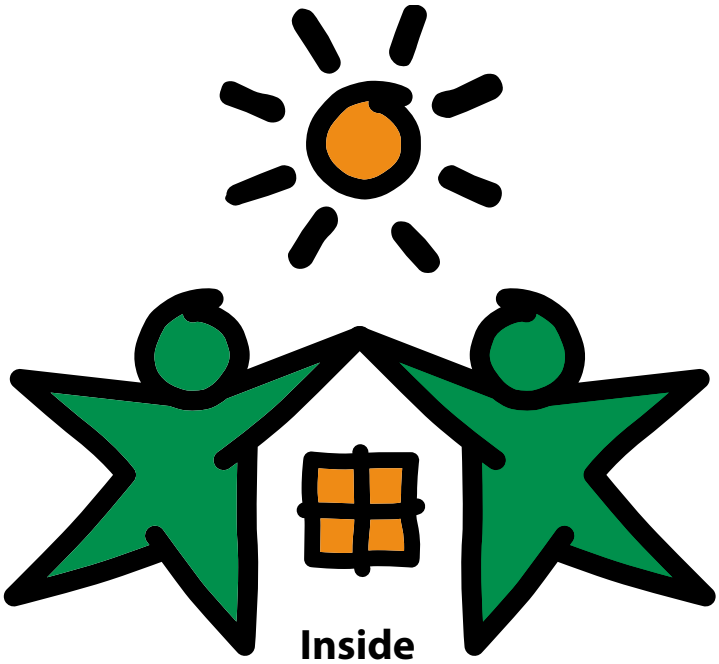
___ Victims of Crime (VOC)

___ Private Pay

___ Grants and Contracts

___ Private Health Insurance

Oral/Dental Health Services



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Oral/Dental Health Services

Oral Health Care Programs and 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); 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.

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	**Denti-Cal for families**
(800) 423-0507	**Denti-Cal for providers**
(800) 422-9495	**Denti-Cal Application Help**
	Denti-Cal Providers accepting new patients
Web site	**http://www.denti-cal.ca.gov/provreferral/Alameda.pdf**

California Children's 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 **(510) 208-5970** **California Children's Services (CCS)**

UCSF Benioff 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** **UCSF Benioff Children's Hospital Oakland Dental Clinic**

Eastmont Wellness Center General Dentistry for Children

Eastmont offers general dentistry for children and youth up to age 16 and accepts 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.

Oral Health Care Programs (continued)

(510) 567-5770 **Eastmont Wellness Center**
6955 Foothill Blvd , Suite 200
Oakland, CA 94612-2413

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

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** **UCSF Center for Orofacial Pain**
(415) 502-6489 FAX 707 Parnassus Ave., Room D1050
San Francisco, CA 94143-0755

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 any age, any disability

(415) 929-6550 **UOP Pediatric Clinic**
2155 Webster St.
San Francisco
Accept children (0 up to age 15)

(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 Alameda County 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.

Contact **(888) 604-4636** **Referrals for dentists and dental clinics**

Oral Health Care Programs (continued)

Regional Center of the East Bay (RCEB)
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.

Contact **(510) 618-6100** **Regional Center of the East Bay (RCEB)**

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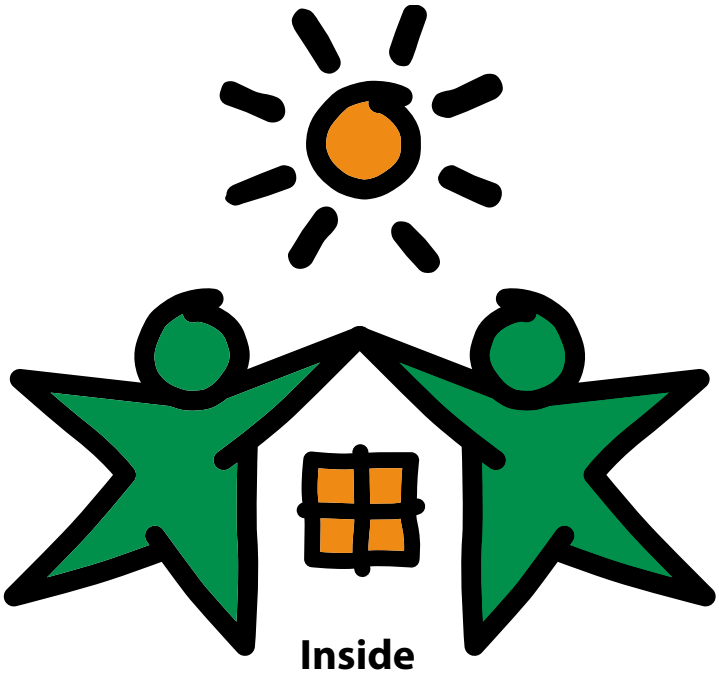
Family Assistance



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

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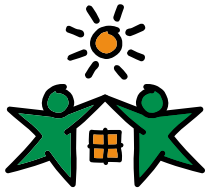
CalWORKs



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**
(888) 999-4772	**Alameda County Social Services Agency / CalWORKs**
	Self Sufficiency Centers CalWORKs/Food Stamps:
(510) 891-0700	**2000 San Pablo Ave., Oakland**
(510) 383-5300	**Eastmont Town Center, 6955 Foothill, Oakland**
(510) 670-6000	**24100 Amador, Hayward**
(510) 795-2428	**39155 Liberty, Fremont**
(925) 455-0747	**3311 Pacific, Livermore**

Food Assistance Programs

Alameda County Community Food Bank
Provides same-day, emergency food assistance, Monday through Friday.

Contact Information	**(800) 870-3663**	**Alameda County Community 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**

Food Stamp Program (FSP)
The Food Stamp Program 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		**Self Sufficiency Centers CalWORKs/Food Stamps:**
	(510) 891-0700	**2000 San Pablo Ave., Oakland**
	(510) 383-5300	**Eastmont Town Center, 6955 Foothill, Oakland**
	(510) 670-6000	**24100 Amador, Hayward**
	(510) 795-2428	**39155 Liberty, Fremont**
	(925) 455-0747	**3311 Pacific, Livermore**

Women, Infants & Children (WIC) Program
Supplemental food and nutrition
[see WIC Program information in Health Services section of binder]

Contact Information	**(888) WIC-WORKS**	**WIC California toll-free Information Line**
	(888) 942-9675	
	(510) 595-6400	**WIC Alameda County**
	(510) 981-5360	**WIC Berkeley**
	(510) 595-6470	**Breastfeeding Help**
	Web site	**http://www.wicworks.ca.gov**

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Housing

Housing information is available at EDEN I&R (Information & Referral), a nonprofit agency based in Hayward that serves all of Alameda County. EDEN I&R maintains a computerized database of over 43,000 units of housing in Alameda County and provides free information on housing-related services for property managers or for persons seeking housing.

Services

EDEN I&R's Housing Services began in the form of its CHAIN (Community Housing And Information Network) Phone Line, which provided housing and service information in 1989 in response to the Loma Prieta earthquake. It was originally set up to help those displaced by the earthquake to locate affordable rentals. Twenty years later, The CHAIN Phone Line continues to connect property managers with eligible persons seeking housing. Information is provided free by phone to individuals and families seeking housing, and landlords pay nothing to list their properties.

Contact Information

211	**EDEN I&R Information on Housing in Alameda County**
Web site	**http://www.edenir.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.

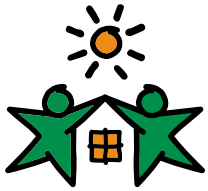
Individuals may apply for IHSS over the telephone.
Staff will take application information and forward the information for follow-up, which will include a home call and services assessment.

Contact Information

(510) 577-1800 **IHSS Telephone Applications**
(510) 577-1803 **FAX**

Web site **http://www.cdss.ca.gov/agedblinddisabled/PG1296.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*	• 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	• 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	**Social Security Administration**
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.

Regional Center of the East Bay (RCEB) and **California Children's 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:

- 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…	**Special Education Local Planning Area (SELPA) Office:**
(510) 525-9800	**SELPA - Alameda/Albany/Berkeley/Emeryville/Piedmont**
(510) 879-8100	**SELPA - Oakland**
(510) 537-3335x1220	**SELPA - Castro Valley/Hayward/San Leandro/San Lorenzo**
(510) 659-2569	**SELPA - New Haven/Newark/Fremont**
(925) 426-9144	**SELPA - Dublin/Livermore/Sunol Glen/Mountain House Elementary/Pleasanton**

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's Services (CCS) may meet some transportation needs for CCS-eligible children.

Contact Information

Call your…	**Medical Facility/Hospital**
Call your…	**Medical/Health Agencies**
(510) 208-5970	**California Children's Services (CCS)**
CCS Web site	**http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx**

Transportation Programs and Services (continued)

Public Transportation

Many areas in Alameda 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 Alameda County (AC Transit, Tri Valley's WHEELS Dial-a-Ride, and Union City Transit) are 100% equipped with lifts for wheelchair users and others who need assistance boarding the bus.

ADA Paratransit

Paratransit is transportation for seniors and persons with disabilities who are unable to use BART or any of the bus systems. ADA (Americans with Disabilities Act) paratransit is designed to complement BART and the bus systems and may not provide the service desired by all seniors and persons with disabilities. All ADA paratransit is prescheduled at least one day in advance and the fare is limited to double the applicable bus fare. Some city-based paratransit programs require users to apply for ADA paratransit. In Alameda County, ADA paratransit is provided by:

- East Bay Paratransit, in those portions of the county served by AC Transit and BART
- Livermore-Amador Valley Transit Authority (WHEELS Dial-a-Ride), in the Tri-Valley
- Union City Transit, in Union City.

City-Based Paratransit

Many Alameda County cities provide their own paratransit programs, in addition to the ADA program that operates in each jurisdiction. City-based programs are funded mostly by the local transportation sales tax known as measure B.

Contact Information

(510) 891-4700	**AC Transit**
(800) 448-9790 TTY	**AC Transit**
(510) 465-2278	**BART Oakland, Berkeley**
(510) 441-2278	**BART Hayward/San Leandro/Fremont/Union City/ Dublin/Pleasanton**
(510) 839-2220 TTY	**BART - hearing impaired**
(510) 287-5000	**Alameda County Paratransit**
(800) 555-8085	**Alameda County Paratransit, toll free**
(510) 287-5065 TTY	**Alameda County Paratransit**
(925) 931-5376	**Pleasanton Paratransit**
(925) 455-7510	**Tri-Valley WHEELS Dial-a-Ride**
(510) 675-5373	**Union City Paratransit**
(510) 583-4230	**Hayward Paratransit**
(510) 208-5970	**California Children's Services, clients only**
(510) 618-6100	**Regional Center of the East Bay (RCEB), clients only**

East Bay Paratransit Frequently Asked Questions

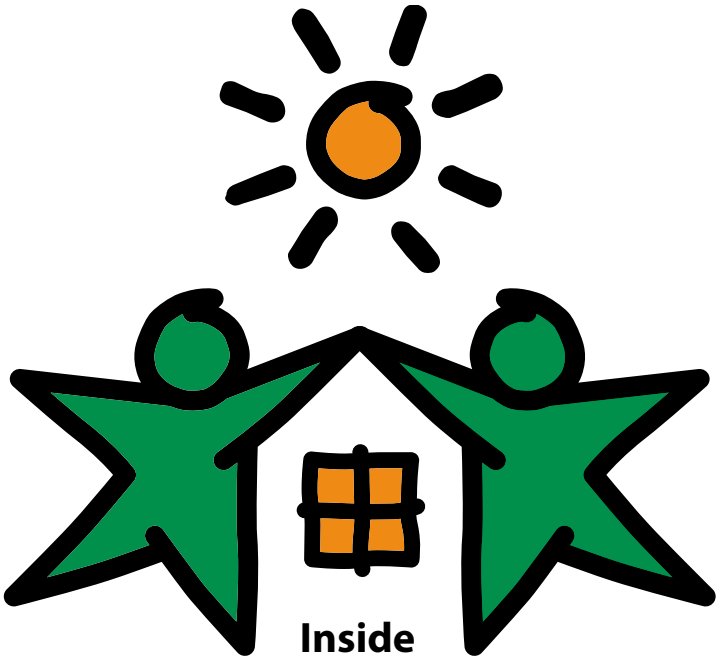
East Bay Paratransit Useful Information	
What is East Bay Paratransit?	East Bay Paratransit (EBP) is transportation for people who are unable to use AC Transit buses or BART trains because of a disability or a disabling health condition. It is sponsored by AC Transit and BART to meet the requirements of the Americans with Disabilities Act (ADA). Rides from your starting location to your destination are provided in a sedan or lift-equipped van. It is not necessary for the rider to wait at a bus stop or to go to a BART station.
Where is service available?	Service is available in the same area where AC Transit operates—from Richmond/Pinole in the North, to Fremont in the South, and to Castro Valley in the East. 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 AC Transit buses or BART trains are running in each particular area. EBP'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 EBP logo. You will share the vehicle with other paratransit riders.
How can I receive the service?	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 EBP 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. To receive an application to apply for eligibility, or for more information, call EBP's Certification Department at the number at the end of this information. Certification must be renewed every three years.
Once I am certified, how can I make a trip?	You must make a reservation to schedule your ride. EBP takes reservations up to seven days in advance. The reservation center is open for calls between 7:00 am to 7:00 p.m., seven days a week. 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?	To make a reservation, you will be asked for this information for both the pick-up and drop-off locations: • Street address, City, Zip Code • Phone numbers • Desired pick-up time • Appointment time
What do I do on the day of my trip?	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. If your ride is late, you may call customer services at EBP to find out the estimated time of arrival.

East Bay Paratransit Frequently Asked Questions (continued)

East Bay Paratransit 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 cannot move a person in a wheelchair up or down steps.
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 for 30 days.
How much do I pay for my trip?	The fare depends on the length of the trip you are taking. The reservationist and the driver will both let you know the amount of the fare: **Distance Fare within the East Bay (as of 06/15)** 0-12 miles: $4.00 12-20 miles: $6.00 >20 miles: $7.00 **Disatnce Fares from the East Bay to San Francisco (As of 06/15)** Fares range between $6 and $10 for trips to San Francisco and Daly City depending on the distance of the trip. San Francisco trips which go beyond the BART service territory that are carried by East Bay Paratransit also pay an additional MUNI Paratransit fare of $2. Fares can be paid either in exact change or with EBP tickets. EBP ride tickets are available by mail from EBP, at the AC Transit and BART ticket offices, and at some stores. There is no fare for personal care attendants, but a companion traveling with you pays the same fare as you do. Transfer trips to other paratransit services and trips to points in San Francisco may have additional charges.
What if I have a problem with my ride?	Customer service staff are available on the telephone during all hours that East Bay 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	**(510) 287-5000**	**East Bay Paratransit General Information**
	(800) 555-8085	**Toll free**
	(800) 555-8085 press 1	**Reservations**
	(800) 555-8085 press 2	**Late Night Inquiries**
	(800) 555-8085 press 3	**Cancellations**
	(800) 555-8085 press 4	**Comments or Complaints**
	(800) 555-8085 press 5	**Certification Phone**
	(510) 287-5065 TTY	**Device for those who are hearing impaired**
	Web site	**http://www.actransit.org/riderinfo/paratransit**

Family Support & Advocacy



Inside

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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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Alameda Alliance for Health (AAH) Health Education Classes

Alliance members have Health Education classes available to them at no cost. Class information is included in the newsletter, *The Alliance Alert*. If any topic of interest is not listed, providers or members can call Health Promotion and they will try to locate a class or service that meets the member's needs.

Services

Alameda Alliance for Health offers a wide choice of health education classes and activities. The classes are designed to give members the self-care skills to keep the family in the best of health. To help reach goals, such as quitting smoking or eating healthy, classes are held throughout Alameda County and are free to members. Interpreter services are available at classes for all members; transportation is available for Medi-Cal members.

Here are some of the classes available to Alliance members:

Classes Available

Prenatal & Infant Classes
- Your Pregnancy
- How to Stop Smoking
- Breastfeeding
- Childbirth
- Infant Care

Parenting Classes
- How to be the Best Parent
- Positive Discipline Tips
- Stages of Development (0–5 years)
- Self-Care Skills for Parents
- Helping Little Ones Eat Well

Safety for You & Your Child
- Car Seat Safety
- Helmet Safety
- Safety in the Home
- Keeping Children Safe
- Babysitter Training

General Health & Wellness
- Forming New Health Habits
- Weight Management
- Quit Smoking
- Healthy Relationships
- Stress Management
- Fitness Tips
- Good Nutrition in Your Culture
- CPR

Special Health Challenges
- Living with Diabetes
- Living with Asthma
- High Blood Pressure
- High Cholesterol

Contact Information

(510) 747-4577
Classes Available

Health Promotion
Alliance Health Education classes
healthpromotion@alamedaalliance.org

(510) 747-4500
(800) 735-2929 TDD
(877) 747-4508 FAX
Email

Alameda Alliance for Health
1240 South Loop Road
Alameda, California 94502
healthpromotion@alamedaalliance.org

Note

See binder Section H for Wellness Program Request Forms in English, Spanish, Chinese and Vietnamese

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Alameda County Family Justice Center (ACFJC)

Alameda County Family Justice Center is a 1-stop center with 30 onsite and over 50 offsite agencies that provide effective, comprehensive services to victims of interpersonal violence in a collaboarative and coordinated manner. ACFJC client navigators link clients to the services that they request, and services are available to all victims regardless of whether or not they have filed a police report.

Services

What services are provided?

- Crisis intervention
- Emergency shelter
- Counseling for adults and children
- Case management
- Legal assistance and information
- Housing assistance
- Self-sufficiency programs
- Children's programs
- Law enforcement investigation
- Childcare while parent or guardian is receiving services onsite
- Victims Compensation Program application assistance
- Safe at Home application assistance
- Restraining Orders (for more information see the Family Violence Law Center on page E-25)

All services provided at the ACFJC are free of charge.
Services are available in English, Spanish and ASL. A language line is used for all other languages.

Contact Information

(510) 267-8800	**Alameda County Family Justice Center** **470 27th Street** **Oakland, CA 94612**
Web site	**www.acfjc.org**
email	**info@acfjc.org**
(800) 799-SAFE **(800) 787-3224 TTY**	**National Domestic Violence Hotline**

Resources

Domestic Violence Resources	
Phone	**24-Hour Hotlines for Assistance/Shelter**
(510) 536-SAFE	A Safe Place (Oakland)
(877) 751-0880	Asian Women's Shelter (San Francisco)
(866) 292-9688	Building Futures for Women and Children (San Leandro)
(877) 503-1850	La Casa de las Madres (San Francisco)
(510) 786-1246	Ruby's Place (Hayward)
(510) 794-6055	SAVE (Fremont)
(800) 884-8119	Tri-Valley Haven (Livermore)
(877) 384-3578	Woman, Inc. (San Francisco)
	Counseling
(510) 437-4688	ACMC Medical Social Services
(510) 535-6200	Casa Del Sol (Oakland)
(415) 777-5500	Communities United Against Violence - Gay & Lesbian (San Francisco)
(510) 268-3770	East Bay Agency for Children (Oakland)
(510) 267-8847	Healing Emotions and Loss After Domestic Violence (HEAL)
(510) 536-4764	Mujeres Con Esperanza (Oakland)
(800) 215-7308	NARIKA - South Asian (East Bay)
(800) 799-SAFE	National Domestic Violence Hotline
(800) 4A-CHILD	National Child Abuse Hotline
	Legal Assistance
(510) 251-2846	API Legal Outreach - Family Law & Immigration
(510) 663-4744	Bay Area Legal Aid - Domestic Violence
(510) 208-0220	Family Violence Law Center - Restraining Orders

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 Information

(510) 286-0439	**Area Board V**
(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

HMO 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	**Health Plan and Provider Line**
(877)525-1295	**Toll-Free Provider Complaint Line**
(916) 255-5241 FAX	
(877) 688-9891 TDD	
Web site	**http://www.hmohelp.ca.gov**

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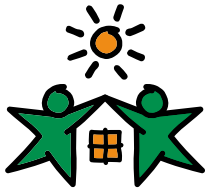
Center For Independent Living (CIL)



Center for Independent Living (CIL) is a national leader in helping people with all forms of disabilities to live independently and become productive, fully participating members of society. CIL is consumer-driven, with employees and board members comprised of individuals with disabilities. CIL offers a comprehensive package of services to people with disabilities.

Services

CIL Services	
Personal Assistance Services (PAS)	Recruits, interviews, and refers personal assistants (PAs) to consumers who require attendants for personal care tasks and/or domestic duties. A computer registry helps match PAs to consumers on the basis of needs and preferences. Management training can be provided to consumers; job skill training to PAs.
Blind Services	Individual peer counseling, support groups, independent living skills, reader referral and information on aids and equipment is provided to blind and low vision consumers. Specialized equipment is available for rent or use; also certification for Recordings for the Blind and Books On Tape.
Client Assistance Project (CAP)	CAP is a federally mandated program to advocate for applicants, consumers and former consumers of the Department of Rehabilitation and all programs funded under the federal Rehabilitation Act. CAP helps consumers to understand Department of Rehabilitation requirements and services, resolve communication problems, know their rights and responsibilities; and may represent consumers at administrative reviews and hearings.
Deaf & Deaf/Blind Services	Provides services to individuals who are deaf, hard of hearing and deaf/blind. Services include peer counseling, sign language interpretation, translation of written correspondence from English to American Sign Language (ASL), communications interpreting, referral, advocacy, independent living skills training, information and referral, and pro-vocational counseling to help identify career goals.
Employment Services	Job seekers with disabilities receive assistance in identifying job goals, gaining interviewing and resume writing and job search skills. Consumers also receive job referral and follow-up counseling.
Financial Benefits Counseling	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 is available to consumers who live in Berkeley and Oakland and for persons with psychiatric disabilities who are also homeless within Alameda County. CIL helps consumers find and keep affordable/accessible housing, learn about rental assistance programs, utility discount programs and other resources and benefits. CIL maintains current housing listings, contact with local property owners and can refer to emergency shelters. CIL provides disability rights information and advocacy related to housing, such as fair housing laws, legal referrals and negotiations with property owners. CIL provides modest home modifications, such as construction of wheelchair ramps, to low-income consumers who live in Berkeley,

Services (continued)

CIL Services (continued)	
Independent Living Skills (ILS)	Peer counselors provide workshops, support groups, and individual instruction in independent living skills/care, pre-vocational counseling and training, socialization skills, and home modifications and aids. **"Moving On"** is a CIL program for persons (age 16 and up) who have physical and/or developmental disabilities and are Regional Center clients, to work 1:1 with a trainer in achieving independent living goals, such as learning how to take public transit and budgeting money.
Information and Referral	Information about disability issues and referral to other agencies with services to the disabled community are provided to the public and to CIL consumers.
Legal Clinic	Attorneys from the Alameda County Bar Association meet individual clients by appointment once a month to discuss legal questions regarding discrimination, wills, consumer landlord/tenant contracts, family law, divorce, child custody, criminal, and housing. These attorneys do not take cases.
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.
Youth Services	Individual and family counseling is provided to disabled youth (ages 14 up to 22) and their families. Assistance and advocacy is provided to students in achieving Individualized Education Plan (IEP) goals and to families in facilitating IEPs. Youth services also offers parent workshops and support groups, disability sensitivity training in schools, technical assistance to special education and general education teachers in accommodating students with disabilities, and offers seasonal youth activities.

Enrollment/ Eligibility

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

(510) 841-4776
(510) 356-2662 Videophone
(510) 841-6168 FAX

CIL Berkeley
3075 Adeline Street, Suite 100 (at Ashby BART)
Berkeley, CA 94703

(510) 763-9999
(510) 763-4910 FAX

CIL Oakland
1904 Franklin Street, Suite 320
Oakland, CA 94612

(510) 536-2271
(510) 261-2698 FAX

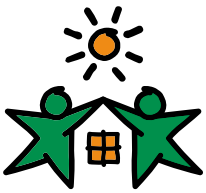
Centro de Vida Independiente CIV Fruitvale
Spanish Speaking Citizens Foundation
1470 Fruitvale Avenue
Oakland, CA 94601

Web site

http://www.cilberkeley.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)**
(510) 259-1800	**Alameda County Child Protective Services (CPS) Hotline:** Under 18 and being physically, sexually or emotionally abused
(800) 422-4453	**National Child Abuse Hotline (for CPS number in your area)**
(800) 309-2131	**Alameda County Crisis Hotline:** Children/youth who might hurt themselves or someone else
(800) 843-5200	**California Youth Crisis Line – Runaway Hotline**
	Alameda County Emergency or "Runaway" Shelters:
(510) 843-3700	**Multi Agency Service Center**
(510) 839-0929	**DreamCatcher**

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

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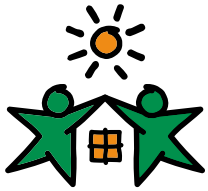
Community Alliance for Special Education (CASE)



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 to 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 Information

(415) 431-2285 ext. 2100	**Community Alliance for Special Education (CASE)**
(415) 431-2289 FAX	**1550 Bryant Street, Suite 738**
	San Francisco, CA 94103
email	**info@caseadvocacy.org**
Web site	**http://www.caseadvocacy.org**
(510) 574-2140	**Fremont Youth and Family Services**
	39155 Liberty Street Suite E500
	Fremont, CA 94537

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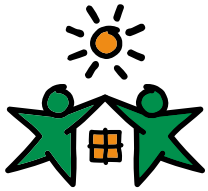
Disability Rights California (DRC)
(formerly Protection & Advocacy - PAI)



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:

- Have a developmental disability
- Are Regional Center clients
- 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
- Are patients in a state psychiatric hospital
- Have a disability as defined in the Americans with Disabilities Act (ADA), and are not eligible under other protection and advocacy programs
- 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:

- Americans with Disabilities Act (ADA)
- Advocacy
- Assistive Technology
- Government Benefits
- Health Benefits
- Housing
- Immigration
- In-Home Supportive Services (IHSS)
- Information on Protection & Advocacy, Inc. (PAI)
- Lanterman Act (Regional Center Services)
- Medi-Cal/Medicare/Medicaid
- Mental Health
- Newsletters
- Investigation Reports
- Social Security (SSI/SSDI/SSP)
- Special Education
- Transportation

Contact Information

(510) 267-1200
(800) 776-5746
(800) 719-5798 TTY
(510) 379-4129 Videophone

Disability Rights California (DRC)
1330 Broadway, Suite 500
Oakland, CA 94621

(916) 504-5810
(916) 514-5820

Office of Patients' Rights
Office of Clients' Rights Advocacy (OCRA)
[see OCRA information in this section]

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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.

Parent Training & Information (PTI)Center

DREDF runs a Parent Training & Information (PTI) Center for Alameda, Contra Costa and Yolo counties. Education Advocates, who are parents of children with disabilities, offer direct assistance and training to parents to help guide them through the special education process, and to enable families to solve problems and become effective advocates for their children. In addition, DREDF Education Advocates serve families of children with disabilities who do not qualify for special education under IDEA, but who qualify for anti-discrimination protections under Section 504 of the Rehabilitation Act. Education Advocates also train professionals who serve children. Free services.

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, kincare 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
(800) 348-4232
(510) 841-8645 FAX/TTY

Disability Rights Education & Defense Fund (DREDF)
Ed Roberts Campus
3075 Adeline Street (at Ashby BART)
Suite 210
Berkeley, CA 94703

email **info@dredf.org**
DREDF Web site **http://www.dredf.org**

PTI **http://dredf.org/special-education/parent-training-and-information-center/**
FYRE **http://dredf.org/special-education/foster-youth/**
Special Ed Resources **http://dredf.org/special-education/**
Training Materials **http://dredf.org/special-education/trainings/**

FamilyPaths
(formerly Parental Stress Service - PSS)

FamilyPaths (formerly Parental Stress Service), through its network of services, strives to provide the tools to enable individuals to become better parents, which in turn allows children to flourish in healthier home environments. When families have access to responsive and effective services they are more likely to develop better resources for coping with stress and to expand their repertoire of disciplining and child management skills.

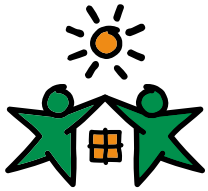
All children deserve a consistent, healthy home environment to enhance their potential in life regardless of socioeconomic background. The early years of a child's life are the most critical to healthy development. Prevention of child abuse correlates positively with healthier parenting and family functioning.

Services

FamilyPaths Network of Services	
Family Hotline 24 hrs/7 days	Support Hotline serves parents, caregivers and children with counseling, crisis intervention and referral to community resources.
Respite	Up to 24 hours of emergency respite childcare relieves stressed families and provides a safe environment for children when parents are in need.
Training	PSS conducts three, 30-hour trainings annually for hotline volunteers. The training prepares volunteers to answer the 24-hour hotline and respond to the diverse needs of families in need in Alameda County. PSS clinical staff receive weekly in-service trainings on topics related to child, adult and family therapy techniques. PSS also sponsors community trainings for mental health and social service professionals who serve families in Alameda County.
Positive Parenting	PSS teaches mutual respect, communication skills, stress management, child development, positive discipline and confidence building.
Foster PAL 24 hrs/7 days	Provides a lifeline when behaviors are challenging, guidance to appropriate resources or just someone to talk to about the unique concerns of caring for foster children.
Counseling	Parents, children, individuals or couples seek support to reduce conflict, overcome traumas and build family strengths. PSS offers specialized treatment for physically, emotionally and sexually abused children as well as for adults abused as children.
Families In Transition	Intensive, practical and therapeutic support for children and young adults at risk of being removed from their homes or transitioning back into their communities. Services last as long as the child continues to meet the qualifications for the program.
CalWORKs	For parents transitioning from welfare to work, PSS provides counseling, parenting/life-skills classes and connections to jobs, resources and other people experiencing similar issues.
Probation	The Probation program provides comprehensive services, including parent education classes, counseling and case management to parents and teens involved with Alameda County Community Probation.

Contact Information	**(510) 893-5444** **(800) 829-3777**	**Family Support Hotline – 24 hrs/7 days**
	(510) 893-9266 **(888) 580-3725**	**Foster Parent Advice Line - FosterPAL** **24 hrs/7 days**
	(510) 893-9230 **(510) 893-2074 FAX**	**FamilyPaths - Oakland** **1727 Martin Luther King, Jr. Way, Suite #109** **Oakland, CA 94612**
	(510) 582-0148 **(510) 582-8460 FAX**	**FamilyPaths - Hayward** **22455 Maple Court, Suite #402** **Hayward, CA 94541**
	(510) 790-3803 **(510) 790-3805 FAX**	**FamilyPaths - Fremont** **39155 Liberty St., Suite #F600** **Fremont, CA 94536**
	Web site	**http://www.familypaths.org**

Family Resource Navigators (FRN)



Family Resource Navigators (FRN) provides parent-to-parent support, information and referral for families of children with developmental delays, disabilities, social emotional concerns and special health care needs. FRN primarily serves Alameda County families of young children (0 to 5) as well as those eligible for California Children's Services (0 to 21).

Services

FRN's Peer Staff and Volunteers:

- Provide emotional support to family members over the phone or at our drop in office.
- Offer one-on-one help with system navigation to help parents connect to services their children need (in collaboration with Alameda County Help Me Grow and CCS).
- Sponsor trainings and workshops on issues important to families raising a child with special needs.
- Create opportunities to connect with other families through support groups and parent/child playgroups.
- Run a volunteer staffed IEP clinic where families can get help on special education issues from trained parent mentors.
- Conduct outreach to families, professionals and community members about services available to young children with developmental delays.
- Mentor parent leaders through trainings and opportunities to become stronger advocates for their children, families and community.

Eligibility

Who is eligible?

Services are available for any Alameda County family with a young child with developmental concerns (0 to 5) as well as for those with a child eligible for CCS (0 to 21). Parent leadership programs and volunteer run programs (such as the IEP clinic) are open to all Alameda County residents. All services are free of charge, and staff speak English, Spanish, Arabic, Farsi, Cantonese, Mandarin, Korean, French and Vietnamese.

Contact Information

(510) 547-7322	**Family Resource Navigators (FRN)**
(510) 296-5768 FAX	**291 Estudillo Drive**
	San Leandro, CA 94577
email	**info@frnoakland.org**
Web site	**http://www.frnoakland.org**

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Family Violence Law Center (FVLC)

Family Violence Law Center's (FVLC) mission is to eliminate domestic violence through self-empowerment of battered women. By helping individual women rebuild violence-free lives and making extensive community education and prevention efforts, FVLC is working to make domestic violence in intimate relationships unacceptable in our society.

Services

What services are provided?

- Options and Crisis counseling via the FVLC Crisis Line
- Information and Referrals
- Comprehensive Legal services, including:
  - help in obtaining restraining orders
  - civil and criminal court accompaniment
  - assistance with custody, visitation and child support issues if client is a victim of domestic violence or seeking a restraining order
  - advocacy with police, prosecutors and court-ordered mediators
  - paperwork assistance and limited representation in divorce cases involving domestic abuse
- Legal Assistance for Victims (L.A.V.) Program
- Criminal Justice Program in collaboration with Oakland & Berkeley police
- Medical Sites Program: victim intervention & medical staff training
- Overnight Emergency Response Team (ONERT): nights/weekends
- Oakland Relationship Abuse Prevention (R.A.P.) Project: violence prevention education for youth, parents, educators & providers
- Domestic Violence Peer Support Groups
- Women in Prison Outreach Program
- Safe at Home Confidential Address Program: confidential P.O. Box address free of charge to victims of domestic violence
- Community Outreach & Education

Services are available in English and Spanish.
Sliding scale for fees. No one turned away for lack of funds.

Contact Information

(800) 947-8301	**FVLC Crisis Line**
(510) 208-0220	**Family Violence Law Center**
(510) 208-3557 FAX	**470 27th Street**
	Oakland, CA 94612
email	**info@fvlc.org**
Web site	**http://www.fvlc.org**
(800) 799-SAFE	**National Domestic Violence Hotline**
(800) 787-3224 TTY	

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First 5 Alameda County

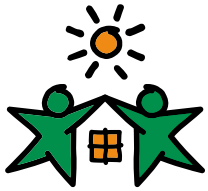
First 5 Alameda County supports a comprehensive system of early childhood care that helps prepare kids for success in school and life. In partnership with the community, we support a county-wide continuous prevention and early intervention system that promotes optimal health and development, narrows disparities and improves the lives of children 0 to 5 and their families.

Services

First 5 Alameda County Services for Providers	
Training @ First 5	Providers from all disciplines who serve children ages 0-5 and their families in Alameda County are welcome to attend training and networking opportunities at First 5. Continuing Education Units are provided free of charge to registered nurses, licensed clinical social workers and marriage and family therapists at all qualified trainings. There is no fee to attend trainings, however registration is required. Please visit http://www.ackids.org/events-training to learn more about specific current topics and to register to attend. You will need to set up a user account and password. For technical assistance with registration, please contact the First 5 Helpdesk at 510-227-6929.
Community Consultation Groups	The Community Consultation Groups offer opportunities to multidisciplinary providers serving children 0-5 to slow down and reflect on their work from a perspective of poverty, race, culture and class. Each group has a focus on a particular cultural group: **Asian Community Consultation Group: (September - June) Supports all providers working with Asian families.** ❖ **Open group - drop in welcome** ❖ **For more information, call or email:** ❖ Amy Szeto, LCSW, 510-869-6075 amys@acmhs.org or ❖ Viviette Catipon, MFT, 510-428-3885 x 8533, vcatipon@mail.cho.org **Communidad: A place for providers Latino Community Consultation Group (September-June) Supports all providers working with Latino immigrant families** ❖ **Open group- drop in welcome** ❖ **For more information, call or email:** ❖ Chela Rios Munoz, LCSW, 510-428-3462, CRiosMunoz@mail.cho.org, or ❖ Martha Rea, LCSW, 510-428-3006, MRea@mail.cho.org **Ujima: African American Community Consultation Group: (October-June) Supports African American service providers** ❖ **Registration Required- 25 members for the year** ❖ **For more information, call or email:** ❖ Rita Lang, MFT, 510 618-2086, Rita.Lang@first5alameda.org

Contact Information	**(510) 227-6949**	**First 5 Alameda County** **1115 Atlantic Avenue** **Alameda, CA 94501**
	Web site	**http://www.ackids.org**
		Program Administrator **Beth Hoch**
	email	**beth.hoch@first5alameda.org**

Health Consumer Alliance (HCA)



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, 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

Alameda County's Health Consumer Center:

(855) 693-7285
(510) 250-5294 FAX

Health Consumer Center at Bay Area Legal Aid
1735 Telegraph Ave
Oakland, CA 94612

Web site **http://healthconsumer.org**

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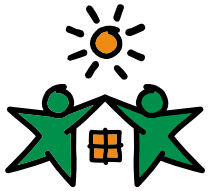
Office of Clients' Rights Advocates (OCRA)



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 this section]

Services

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

- 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

Contact Information

(800) 390-7032	**Office of Clients' Rights Advocates**
email	**OCRAInfo@disabilityrightsca.org**
Web site	**http://www.disabilityrightsca.org/OCRA**

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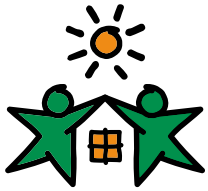
Procedural Safeguards and Referral Services (PSRS)



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.

Services

PSRS can provide:

- 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
(916) 374-7182 VP
(916) 327-3704 FAX

Procedural Safeguards and Referral Services (PSRS)
1430 N Street, Suite 2401
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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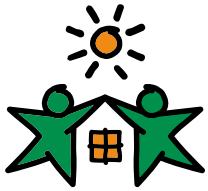
Respite Care



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.

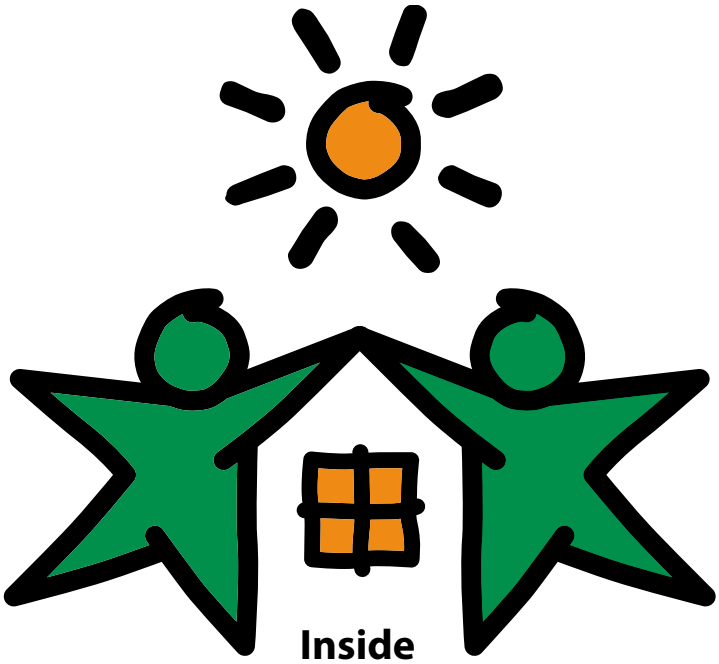
Agencies

Alameda County Agencies with Respite Care Services for Families	
Regional Center of the East Bay	
500 Davis Street, Suite 100 San Leandro, CA 94577 **Phone** **(510) 618-6100** FAX (510) 678-4100 Web site www.rceb.org	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.
Bay Area Crisis Nursery	
1506 Mendocino Drive Concord CA 94521 0-5 Years **(925) 685-8052** 6-11 Years **(925) 685-3695** Office **(925) 685-8052** Web site www.bayareacrisisnursery.org	Provides a temporary home for children (birth up to age 11) of parents who are unable to cope during times of stress or crisis. Services are free, voluntary and confidential. **Crisis Nursery Intervention:** Program assists families when there is an immediate need for a family to admit children (birth up to age 5) due to a crisis or stressful situation. Average stays 7–10 days. Parents self refer. **Respite Care:** Prearranged 48-hour stays once per month for up to 6 months, if needed, for children (birth up to age 5) after the crisis. Admission through recommendation of Crisis Nursery staff who've worked with family in crisis intervention.
Childcare Resource & Referrals	
North County **(510) 658-0381** Bananas **Mid County** **(510) 622-2614** 4 Cs **Tri Valley** **(925) 417-8733** Childcare Links	Provides emergency respite of 0 to 6-month stays for children (birth up to age 12) who are or who are at risk of being abused or neglected, or who are homeless. Referrals are from the social worker or primary care provider. Format of referral letter available from contact number.

Agencies (continued)

Alameda 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** Web site www.familypaths.org	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.
Family Support Services of the Bay Area	
410 Grand Avenue Oakland CA 94610 Respite Phone **(510) 834-4766** Fax (510) 834-4010 Web site www.fssba-oak.org	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.
George Mark House	
2121 George Mark Lane San Leandro CA 94578 **Phone** **(510) 346-4624** Fax (510) 346-4620 Email info@georgemark.org Website www.georgemark.org	Pediatric transitional, respite and end-of-life care facility available to all medically eligible children & their families regardless of ability to pay. Provides 24x7 skilled nursing care for children (birth up to age 19) with life-threatening or terminal conditions. Family apartments available on a reservation basis. Referrals can be made by parent, physicians, or health care agencies.
Respite Inn	
906 Lee Lane Concord CA 94518 **Phone** **(925) 686-5758** Fax (925) 609-8952 Email TheRespiteInn@att.net Web site www.therespiteinn.org	Provides out-of-home respite and emergency services to adults (18 up to age 60) with developmental disabilities (DD). Stays from 1–21 days at a time. Purpose of this respite is to support families to maintain their family member with DD in their own home and to give adults with DD the opportunity to experience a more independent living situation.

Educational & Developmental Services



Inside

- Child Development and Behavioral Pediatrics
- Early Start
- Head Start
- Help Me Grow
- Regional Center of the East Bay (RCEB)
- Section 504 of the Rehabilitation Act
- Special Education

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Child Development and Behavioral Pediatrics

Child Developmental and Behavioral Pediatrics at UCSF Benioff Children's Hospital Oakland provides evaluation, diagnosis, treatment and referral services for children, from birth up to age 20, who have or who are at risk for developmental delay, developmental disabilities and learning or behavioral disorders. Referral to this clinic is through primary care providers.

Services

What services are provided?

- Behavior Disorders Clinic
- Child Development Clinic
- Communication Clinic
- Early Childhood Mental Health (CARE)
- Early Intervention services
- Katie's Clinic for Rett Syndrome
- Neonatal Follow-Up Program
- Parent Infant Program (PIP)/Local Early Access Program (LEAP)
- Psychopharmacology Clinic

Eligibility

Who is eligible for Child Developmental and Behavioral Pediatrics services?
Children birth up to age 20 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

(510) 428-3351
Intake Coordinator
(510) 601-3912 FAX

Child Development and Behavioral Pediatrics
UCSF Benioff Children's Hospital Oakland
5220 Claremont Avenue
Oakland, CA 94609

Web site

http://childrenshospitaloakland.org/main/departments-services/4.aspx

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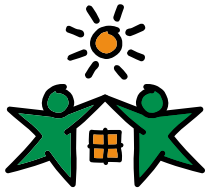
Early Start Program



Early Start is a Regional Center program that provides access to family-centered, early intervention services for eligible infants and toddlers (birth up to age three) who have or may be at risk for a developmental disability or delay.

The developmental domains a Regional Center must consider are:

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

Early Start Services

Early Start services include:

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

- Has a significant delay of at least 33% in one developmental domain.
- Is at high risk of having substantial developmental disability due to a combination of biomedical risk factors.
- Has an established risk condition that may result in a developmental disability (for example: Down Syndrome, Cerebral Palsy, Epilepsy).

Assessment Timelines/ Plan Details

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.

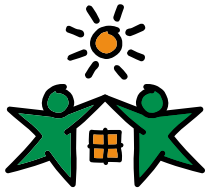
Providers

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.

Contact Information	**(510) 618-6195** **(510) 618-7761 FAX**	**Early Start Program and Prevention Program Intake**
	Address	**Early Start Program and Prevention Program** **Regional Center of the East Bay (RCEB)** **500 Davis Street, Suite 100** **San Leandro, CA 94577**
	(510) 618-6100 **(510) 678-4100 FAX**	**Assigned Service Coordinator / RCEB San Leandro**
	Web site	**http://www.rceb.org**

See Forms section for
Modified Checklist for Autism in Toddlers (M-CHAT)

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.

Funding

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)

Eligibility

Head Start Programs Eligibility	
Early Head Start	• 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	• 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.

Contact Information

(510) 629-6350	**Head Start Alameda**
(510) 848-9092	**Head Start Berkeley**
(510) 238-3165	**Head Start Oakland**
(510) 535-6949	**Head Start Oakland - Fruitvale Village**
(510) 796-9512	**Head Start South County**
(925) 443-3434	**Head Start Tri-Valley**
(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://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc**

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Help Me Grow

Help Me Grow Alameda County is a county wide system to promote the development, learning and social-emotional health of children ages birth to 5. Call 888-510-1211 or e-mail Helpmegrow@first5alameda.org

Services

Help Me Grow Services	
Child Development Assistance & Care Coordination	888-510-1211: The phone line is staffed by multi-lingual Care Coordinators who answer questions and offer support for children's development learning and behavior. Care coordinators also provide referrals and help families get connected to services. The phone line is open Monday-Friday from 9 am - 5 pm. Care Coordinators speak English, Spanish, Mandarin and Cantonese. Interpretation is available for other languages.
Developmental Screening Program	Families enrolled in the Developmental Screening Program regularly receive the Ages and Stages Questionnaire (ASQ) through their child's 5birthday. Staff share results, provide tips, and help address concerns. With permission, results are shared with provider(s).
Family Navigators	Family Navigators are parent professionals who provide in-person care coordination. They offer home visits, language assistance, and peer support. They help families problem-solve, navigate systems, and enroll in services for their child and family.
Supporting Providers	
AlamedaKids.org	**AlamedaKids.org is a new website dedicated to supporting our county's children (ages birth to 5 years) and their families. The website offers families and providers** • Timely, friendly and credible information on child development, learning and behavior • Family support through stories of real families and ways in which families can be resilient and strong • Resources for early child development, parenting and other needs (shelters, clinics, etc.)
Alameda Kids Resource Directory	**Featured on AlamedaKids.org is a new searchable "one-stop shop" directory of early childhood and parenting resources available in Alameda County. The directory has over 200 resources that can be searched by type of service, location, language spoken, and more.**
Connection Café	**Connection Cafés are opportunities for early childhood providers to network, learn about new resources, share information, and hear from speakers on various relevant topics. Cafés are offered every other month.**
Listserve	**The listserve is a fast and informative way of receiving information on early childhood programs, events, and trainings in Alameda County. Partners can also post to the listserve to promote programs and events. The listserve is distributed twice a month.**

Contact Information	**(888) 510-1211**	**Help Me Grow Linkage Line**
	Address	**Help Me Grow** **First 5 Alameda County** **1115 Atlantic Avenue** **Alameda, CA 94501**
	Web site	**http://www.first5alameda.org/help-me-grow** **http://www.alamedakids.org**

Regional Center of the East Bay (RCEB)

Regional Center of the East Bay (RCEB) 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
- Early intervention services 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
- 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 and toddlers (0 up to 36 months)	[See Early Start information in this section]

Eligibility (continued)

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.

Enrollment

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.

Contact Information

(510) 618-6100	**Regional Center of the East Bay (RCEB)**
(510) 678-4100 FAX	**500 Davis Street, Suite 100**
	San Leandro, CA 94577
Web site	**http://www.rceb.org**
(510) 618-6195	**Early Start and Prevention Program Intake/Assessment**

Note

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

Regional Center of the East Bay (RCEB) Purchase of Services Board Policies Guide

Services

RCEB Purchase of Services Board Policies Guide

What are Purchase of Service Policies?

They provide direction to everyone about the kinds of services that Regional Center of the East Bay can provide to people with developmental disabilities and their families.

Therapies
Includes occupational therapy, physical therapy and speech therapy to maximize essential skills and/or to maintain functioning.

Mobility Training

To support consumers in community integration and independence through the use of public transportation.

Genetic Services

Genetic testing and counseling to any parent determined to be at high risk of having a developmentally disabled infant.

Nursing

When a medical condition exists and there is a need for periodic, intermittent relief for the primary caregiver (respite) or continuous nursing intervention.

Supported Living
Services and support for persons to live in homes that they own, lease or rent. Range of services and supports may include: assistance in finding a home; social, behavioral and daily living skills training and support; hiring and training individuals to provide personal care.

Parenting Training
Skills training for parents with a developmental disability, in order to maintain and strengthen the family unit and promote the development of the child.

Residential Service for Adults or Children

For those who prefer to live in a licensed community care home, who need the care and supervision provided by such a facility.

Additional Staff
When a consumer is in immediate danger of placement in a State Developmental Center, or needs to adjust to a new home or program, or when there is a facility which is not staffed to provide the appropriate level of supervision needed by the consumer's temporary illness.

How do you Access Services?

When a team of persons, including the consumer and a representative from the Regional Center and others, (like family members) create the Individual Program Plan (IPP). The IPP has to state why the service is needed, for how long and how you'll know if it helps.

Services (continued)

RCEB Purchase of Services Board Policies Guide (continued)

Infant Programs
Home-based and community-based stimulation programs, which encourage the development and adjustment of infants and maximize the ability of families to better provide for the special needs of their infants.

Counseling and Psychotherapy

For consumers involved with the criminal justice system, whose health and safety are at risk due to dangerous behavior, depression or excessive fear.

Why must RCEB develop Purchase of Service Policies?

The Lanterman Act (a California law) states that regional centers must provide support services that help consumers stay in their local communities and lead lives like everyone else. Each support service has guidelines written in an understandable way.

Transportation
For adult consumers to attend a primary day program, when they are unable to safely use public transportation or when public transportation is not available.

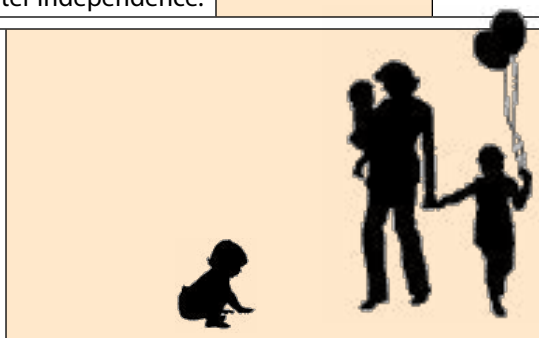
Adaptive Equipment and Supplies
Durable medical equipment such as wheelchairs, bath equipment and personal lifts; small adaptive equipment items; dedicated communication devices that enables the consumer to further interact with his/her environment and leads to greater independence.

Behavioral Services

Assessment, training and consultation with family, caregiver or program staff, for consumers who engage in behaviors that pose a serious threat to their living arrangement or program.

Diapers

For consumers between the ages of 5 and 18 who are incontinent of bowel/bladder with potential for skin breakdown.



Respite
Intermittent relief to families who provide constant care and supervision to the consumer whose care needs are beyond that of persons without disabilities.

Specialized Medical and Dental Care
Must be specifically related to the consumer's developmental disability.

Independent Living Skills
Training in areas necessary for persons to live independently without supervision and support services.

(continued on next page)

Services (continued)

RCEB Purchase of Services Board Policies Guide (continued)				
Early Intensive Behavioral Intervention Group training for parents, assessment of child's behavioral needs, ongoing consultation and monitoring for children under 3 years of age with a diagnosis indicating autism or suspected autism.		Child Care For consumers less than 13 years old, when their parents work on a full-time basis or attend vocationally-oriented educational programs where their schedule cannot accommodate the child care need and who do not have a natural support system which provides child care.		Day Program For adults who have completed public school services to increase their skill levels, prepare for a maximum level of independence in their community and to prepare for work.

Other Things to know about Purchase of Service Policies…

- Services are identified through the planning process (IPP) with your service coordinator.
- Services will be reviewed every so often to see that they are still necessary.
- Services cannot be provided if another agency is responsible unless that agency has stated in writing that they won't provide it.
- If more than one service is available and appropriate, the team must consider which one is most cost effective.

Source Regional Center of the East Bay
Web site **http://www.rceb.org**

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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:
(800) 368-1019	**Office for Civil Rights**
(800) 537-7697 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	• 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.)	• 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	• 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	• 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	• 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	• 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	• 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	• 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.)	• 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)	• 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)	• 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)	• 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)	• 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)	• 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	• 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	• Allow for shorter assignments (quality versus quantity). • Allow alternative method of production (computer, scribe, oral presentation, etc.).
Poorly developed study skills	• 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)	• 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)	• 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)	• 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	• 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)	• 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	• 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	• 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	• 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	• 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	• 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)	• 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)	• 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	• Use air purifier. • Control temperature. • Accommodate specific allergic reactions.

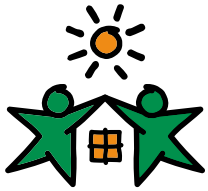
Section 504 Appropriate Accommodations Examples (continued)

Area of Concern	Accommodations
Modification of classroom/building to accommodate equipment needs.	• Plan for evacuation for wheelchair-using students. • Schedule classes in accessible areas.
Building health/safety procedures	• Administer medication. • Apply universal precautions. • Accommodate special diets.
District policies/procedures	• Allow increase in number of excused absences for health reasons. • Adjust transportation/parking arrangements. • Approve early dismissal for service agency appointments.
Staff communications	• Identify resource staff. • Network with other staff. • Schedule building team meetings. • Maintain ongoing communication with building principal.
School/community/agency communication	• 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)	• 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)	• 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.	• 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	• 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	• 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	• 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.

Services What services are provided?

Special Education Services	
Individualized Education Program (IEP) Process	
• 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)	
• 1:1 Instructional Aide (IA) • Adapted Physical Education (APE) • Art Therapy • Assistive Technology (AT) • Audiology services • Counseling and Guidance • Diagnostic Medical Services • Health, Mental 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	• 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.	

Placement 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)

Specialized education and services may be provided in a variety of settings, including:

- 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.

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.

Eligibility

Who is eligible?

A child must have a disability that aligns with at least one of the following categories:

- Autism or autistic-like
- Deafness
- Deaf-blindness
- Hearing impairment
- Mental retardation
- Multiple disabilities
- Orthopedic impairment
- Other health impairment
- Serious emotional disturbance
- Specific learning disability
- Speech and language impairment
- Traumatic brain injury
- Visual Impairment, including blindness

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.

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.

Evaluation Request

How does a person begin the IEP Process?

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.

Timelines/ Procedure

How must the school district respond to a request for special education evaluation?

- 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

	School District Departments of Special Education:
(510) 670-7736	**Alameda County Office of Education**
(510) 337-7075	**Alameda**
(510) 559-6536	**Albany**
(510) 644-8913	**Berkeley**
(510) 537-3000 x1200	**Castro Valley**
(925) 828-2551 x8031	**Dublin**
(510) 601-4907	**Emeryville**
(510) 659-2569	**Fremont**
(510) 784-2611	**Hayward**
(925) 606-3225	**Livermore Valley**
(510) 471-1100 x62616	**New Haven (Union City)**
(510) 818-4209	**Newark**
(510) 879-8100	**Oakland**
(510) 594-2893	**Piedmont**
(925) 426-4293	**Pleasanton**
(510) 667-3507	**San Leandro**
(510) 317-4761	**San Lorenzo**

(916) 445-4613	**CA Dept. of Education (CDE) / Special Education Division**
(916) 323-9779 TTY	**1430 N Street, Suite 2401**
(916) 327-3706 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.
(916) 374-7182 VP	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**
	http://www.disabilityrightsca.org/pubs/PublicationsSERREnglish.htm

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.

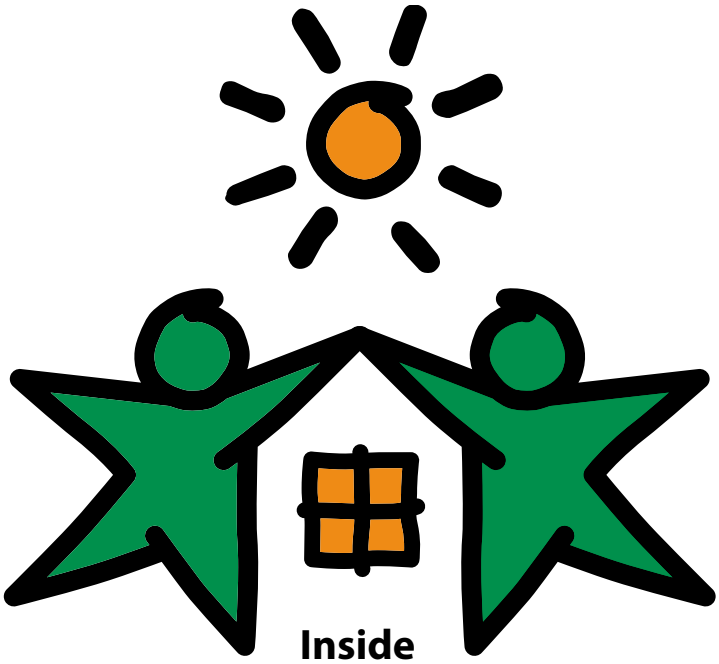
(Describe the service(s) agreed to in your child's IEP that is not being provided by your child's school district, for example:) Both the frequency of therapy and the mode of transportation to therapy are specified in my child's IEP. The district is failing to implement the IEP by refusing to provide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

Transition to Adult Services



Inside

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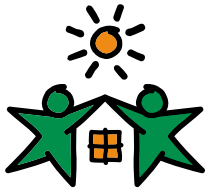
Adolescent Health Transition Project (AHTP)



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/hcp/index.html**
Transition Resources	**http://depts.washington.edu/healthtr/resources/index.html**
Transition Process	**http://depts.washington.edu/healthtr/process/index.html**
Transition and School	**http://depts.washington.edu/healthtr/school/index.html**
Transition Tools	**http://depts.washington.edu/healthtr/resources/tools.html**

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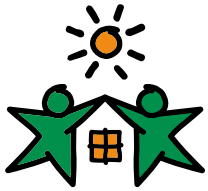
AHTP
Providers & Educators

Making the Transition to Adult Health Care: Information for Health Care Providers & Educators



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

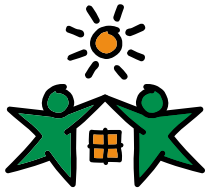
All people are entitled to receive health care in age-appropriate settings, which promote autonomy and enrich social growth. Most adolescents with chronic illnesses or disabilities have much to gain from a timely move to age-appropriate health care or from receiving age-appropriate care from their family 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
Providers & Educators (continued)

Transition Tips for Providers



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
Providers & Educators (continued)

A Special Word To 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,

> *"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 ***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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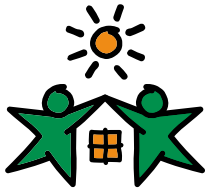
AHTP
Parents & Families

Thinking about the Future: 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

AHTP 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

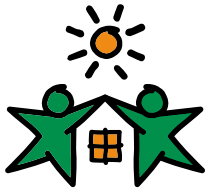
More information about the Health History Summary and testing its usefulness for teens with special health care needs and disabilities is described in the article "Promoting Successful Transition from Pediatric to Adult-Oriented Health Care" in the March 2004 edition of *Exceptional Parent* magazine.

Website Links

Also, for instant pdf downloads of the "how-to" and form, visit these AHTP links:
http://www.depts.washington.edu/healthtr/healthhistory/howto.doc
http://www.depts.washington.edu/healthtr/healthhistory/summary.doc

AHTP Health History Summary

Health History Summary Form



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.			
Fair	**Good**	**Excellent**	
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:		
Name	Relationship	Telephone(s)
		W H
		W H

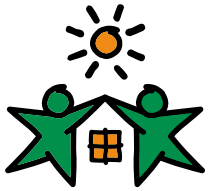
AHTP
Health History Summary (continued)

Activities of Daily Living		
Please answer the following questions:	**Yes**	**No**
Are you visually impaired?		
Do you wear glasses or contacts?		
Are you deaf or hard of hearing?		
Do you use a hearing aid?		
Do you have any speech problems?		
Do you use sign language?		
Is English your preferred language?		
If no, what language do you speak?		
Can you walk?		
Do you use a walker?		
Do you use a wheelchair?		
Do you routinely wear medic alert identification?		
What other aids do you use to accomplish daily activities?		
Are there any restrictions to your daily activities? (Can you drive an automobile? Do you need a computer to communicate? Etc…)		
Your adult doctor will ask you questions in private about your sexuality and about drug, alcohol and cigarette use.		

[End of Health History Summary form]

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)

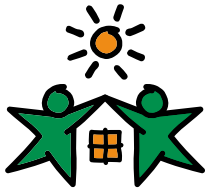
Transition Timeline (continued)
18 up to 22 Years Old (or according to your child's developmental ability)
• You may want to encourage your young adult with an IEP, to stay in a school program up to age 22. • Continue to encourage your young adult with an IEP, to participate in IEP meetings. • Continue 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
• 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
• 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
• 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
Teens & Young Adults

Taking Control of Your Own Health Care: 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?
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.

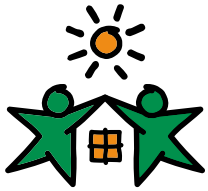
AHTP
Teens & Young Adults (continued)

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!

Autonomy Checklists



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				

AHTP
Autonomy Checklists (continued)

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 Source

http://depts.washington.edu/healthtr/Checklists/intro.htm
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.

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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

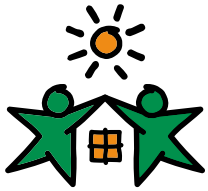
DOR institutes an **"Order of Selection"** if there are more individuals than agency resources. Individuals are placed on a waiting list using a number of criteria that determines their placement on the list.

Alameda County Contact Information	**(510) 883-6000** **(510) 540-3680 TTY**	**CA Department of Rehabilitation** **Berkeley Branch Office** **Ed Roberts Campus** **3075 Adeline Street (at Ashby BART)** **Suite 170** **Berkeley, CA 94703**
	(510) 794-2458 **(510) 797-2493 TTY** **(510) 797-2541 TTY**	**Fremont Branch Office** **39155 Liberty St., Suite F630** **Fremont, CA 94538-1513**
	(510) 622-2764 **(510) 622-2796 TTY**	**Oakland Branch Office** **1515 Clay Street, Suite 119** **Oakland, CA 94612**
	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:**
(510) 525-9800	**SELPA - Alameda/Albany/Berkeley/Emeryville/Piedmont**
(510) 879-8100	**SELPA - Oakland**
(510) 537-3335x1220	**SELPA - Castro Valley/Hayward/San Leandro/San Lorenzo**
(510) 659-2569	**SELPA - New Haven/Newark/Fremont**
(925) 426-9144	**SELPA - Dublin/Livermore/Sunol Glen/Mountain House Elementary/Pleasanton**
Call your…	**Local Community College or Post-secondary Institution's Disabled Student Programs and Services (DSPS) office**

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.

Contact Information

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

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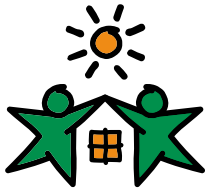
Independent Living Skills Program (ILSP)



Independent Living Program (ILSP) provides training, services and programs to assist current and former foster youth in achieving self-sufficiency prior to and after leaving the foster care system. From its inception, Alameda County ILSP has focused on education, employment, and life skills training. ILSP graduates go on to 4 year colleges, community colleges, vocational training programs, and full time employment.

Services

What services are provided?

The following services are avaliable through Alameda County's Independent Living Skills Program:

- Pre-emanicipation life skills classes
- Job readiness training
- Teen Health Center
- College tours
- College and scholarship application assistance
- Computer classes
- Themed workshops
- Referrals to necessary services such as Medi-Cal

Eligibility

Who is Eligible?

Youths are eligible for ILP services up to the day before their 21st birthday provided one of the following criteria is met:

- The youth was/is in foster care at any time from their 16th to their 19th birthday.
- The youth was/is between the ages of 16 and 18 years of age and participating in the Kinship Guardianship Assistance Payment Program (Kin-GAP).

Enrollment

How do you enroll?

Youth are referred to ILSP by their child welfare workers or probation officers. Together with the child welfare worker or probation officer, a youth should complete a Transitional Independent Living Plan (TILP) prior to referral to ILSP, and the TILP should be sent along with the referral form to Therese Marin-Clenney, either via fax (510) 667-7679 or by email. (If the TILP is not completed prior to referral, the youth will complete a TILP with his or her ILSP trainer, and the TILP will be updated every 6 months.)

Contact Information

(510) 667-7696
(510) 667-7679 FAX

Alameda County ILSP
675 Hegenberger Road, Suite 100
Oakland, CA 94621

Independent Living Program Policy Unit
Child and Youth Permanency Branch
744 P Street, MS 14-78
Sacramento, CA 95814

Web Site **http://www.alamedacountyilsp.org**

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Transitional Housing

Transtional housing is available to current or recently emancipated foster youth through a number of programs designed specifically to meet their needs. These programs help foster youth prepare for emancipation or adequately handle the challenges of life after emancipation.

Services

Transitional Housing Programs	
Transitional Housing Placement Program (THPP)	THPP is a community care licensed placement opportunity for youth in foster care between the ages of 16 and 18 years old. The goal of THPP is to help participants emancipate successfully by providing a safe environment for youth while learning skills that can make them self-sufficient. Participants may live alone, with departmental approval, or with roommates in apartments and single-family dwellings with regular support and supervision provided by THPP agency staff, county social workers, and ILP coordinators. Supportive services include: educational guidance, employment counseling and assistance reaching emancipation goals outlined in a participant's Transitional Independent Living Plan, the emancipation readiness portion of a youths' case plan. The youth must also be participating in the Independent Living Program.
Transitional Housing Program-Plus (THP-Plus)	THP-Plus is a housing program for emancipated foster youth at least age 18 up to their 24th birthday. A person is eligible to participate if the county he/she lived in when he/she aged-out of foster care is participating in the program. A person may also participate in another county if that county accepts them into the program. The same services and housing models are offered as THPP, but the rules about the program will be age appropriate for young adults.
Transitional Housing Placement Plus Foster Care	Transitional Housing Placement-Plus Foster Care (THP+FC) allows eligible foster youth to extend foster care beyond age 18 and up to age 21. This new placement option provides transitional housing and supportive services based on a Transitional Independent Living Plan (TILP).

Eligibility

Who is Eligible?

- Youths in foster care, age 16-18, are pursuing county-approved TILP goals and are participating in, or have participated in, Independent Living Program Services are eligible for THPP.
- Emancipated youths, age 18-24 are eligible for THP-Plus.
- Non-Minor Dependents (NMD), including those supervised by probation, are eligible for placement in THP+FC. Note: Youth in guardianships who are not current dependents are not eligible for placement in THP+FC.

Enrollment

How do you enroll?
Independent Living Skills Program participants who meet eligibility for THPP must make their application through the ILSP Head Trainer. Applications for THP-Plus and THP-Plus Foster Care should be made through the agencies providing these services.

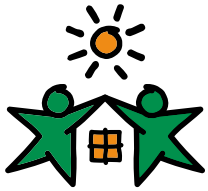
Contact Information

(510) 667-7694
(510) 667-7639 FAX

Beyond Emancipation
675 Hegenberger Road, Suite 100
Oakland, CA 94621

Web Site
www.beyondemancipation.org

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

(510) 273-2360
(510) 452-2070 FAX
Oakland/Alameda ROP
Oakland Unified School District (OUSD)
2607 Myrtle Street, Suite 104
Oakland, CA 94607

(510) 337-7093
(510) 337-7163 FAX
Eden Area ROP
Hayward Unified School District (HUSD)
26316 Hesperian Boulevard
Hayward, CA 94545

Web sites
http://www.carocp.org
http://www.cde.ca.gov/ci/ct/rp

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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]

Programs

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.

Services

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.

Providers

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.

Eligibility

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

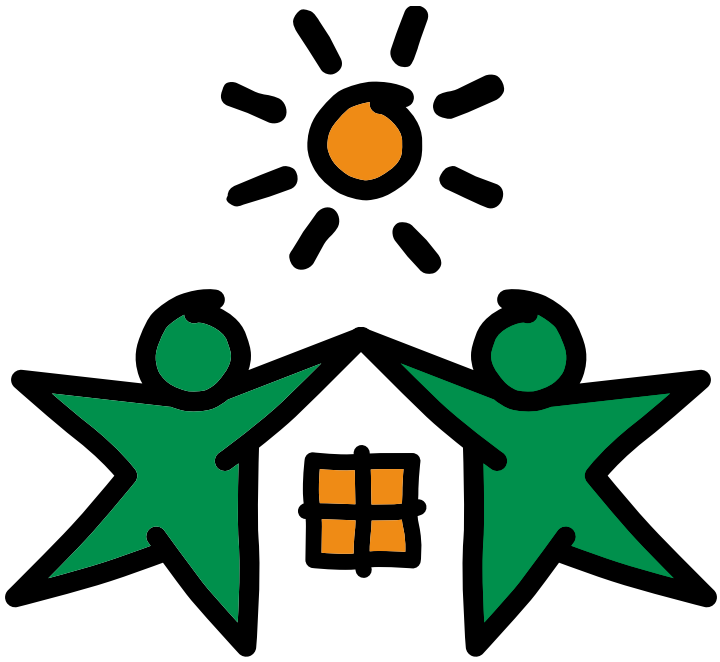
(510) 883-6000	**CA Department of Rehabilitation**
(510) 540-3680 TTY	**Berkeley Branch Office**
	3075 Adeline Street (at Ashby BART)
	Suite 170
	Berkeley, CA 94703
(510) 794-2458	**Fremont Branch Office**
(510) 797-2493 TTY	**39155 Liberty St., Suite F630**
	Fremont, CA 94538-1513
(510) 622-2764	**Oakland District Office**
(510) 622-2796 TTY	**1515 Clay Street, Suite 119**
	Oakland, CA 94612
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:**
(510) 525-9800	**SELPA - Alameda/Albany/Berkeley/Emeryville/Piedmont**
(510) 879-8100	**SELPA - Oakland**
(510) 537-3335x1220	**SELPA - Castro Valley/Hayward/San Leandro/San Lorenzo**
(510) 659-2569	**SELPA - New Haven/Newark/Fremont**
(925) 426-9144	**SELPA - Dublin/Livermore/Sunol Glen/Mountain House Elementary/Pleasanton**
Call your…	**Local Community College or Post-secondary Institution's Disabled Student Programs and Services (DSPS) office**

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

Forms



Inside

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Alameda County Community Resources

Every child deserves a medical home.

California Children Services (CCS)
Specialized medical care for children with eligible medical conditions (0 up to age 21).

510 208-5970

Child Care Referrals
Listings of child care and preschool programs as well as subsidy information. Head Start (HS) and Early HS referrals also available through these resource & referral agencies.

North County 510 658-0381
South County 510 582-2182
East County 925 417-8733

Child Health Coverage
Checkups/immunizations and treatment for low income children (0 up to age 19; 21 if Medi-Cal).

MediCal 888 747-1222
Alameda County Child Health & Disability Prevention (CHDP) 510 618-2070
Berkeley CHDP 510 981-5300

Dental Care (Denti-Cal)
Referrals to dental services for Medi-Cal eligible children (under age 21).

Denti-Cal Application Help 800 322-6384
Alameda Co. Healthy Smiles 510 208-5910

Family Crisis
Services to parents, caregivers & children needing support, legal services or crisis intervention.

FamilyPaths (Parental Stress Services) 800 829-3777
Family Violence Law Center 510 208-0255

Family Resource Network (FRN)
Free information, referral services, advocacy and parent-to-parent support for children with disabilities or special health care needs (0 up to age 22).

510 547-7322

Health Services

VISION: UCB Optometry / Special Visual Assessment Clinic (SVAC) 510 642-2020

HEARING: Center for Early Intervention on Deafness (CEID) 510 848-4800
UCSF Benioff CHO Audiology 510 428-3344
UCSF Benioff CHO Speech and Language 925 979-3440

DEVELOPMENTAL ASSESMENTS: UCSF Benioff CHO Child Development Center 510 428-3351

Mental Health / Drug & Alcohol Abuse
Evaluations and services for those with mental health, drug or alcohol problems (all ages).

Alameda Co. Behavioral ACCESS 800 491-9099
Thunder Road (substance abuse) 510 653-6040

Nutrition & Supplemental Food Programs
Nutrition and breastfeeding counseling, food vouchers, breast pump loans to low-income pregnant or nursing women, infants and children (0 up to age 5) through WIC.

Alameda Co. WIC 510 595-6400
Toll Free WIC 888 942-9675
Berkeley WIC 510 981-5360
Alameda Co. Food Bank Helpline 800 870-3663

Public Health & Other Resources
Information about health referrals.
General county assistance referrals.

Alameda Co. Clearinghouse 888 604-4636
Berkeley Advice Line - Nurse of the Day 510 981-5300
211 Line for Alameda Co. 211

Regional Center of the East Bay (RCEB)
Services for those with developmental disabilities (all ages).
"Early Start" and "Prevention Program" provide services for children (0 up to age 3) with developmental concerns (see back side).

RCEB Main 510 618-6100
Early Start & Prevention Program 510 618-6195

Special Education Local Plan Areas (SELPAs)
Support/oversee special education services delivered by Local Education Agencies (LEAs - public school districts) to IDEA-eligible students with special needs (3 up to age 22); (0 up to age 22) with Low Incidence disability.
(Referral Pad has district numbers)

Alameda County Office of Education 510 670-7736
Alameda/Albany/Berkeley/ Emeryville/Piedmont 510 525-9800
Oakland 510 879-8100
Castro Valley/Hayward/San Leandro/San Lorenzo 510 537-3000
New Haven/Newark/Fremont 510 659-2569
Dublin/Livermore/Sunol Glen/Mountain House Elem./Pleasanton 925 426-9144

Supplemental Security Income (SSI)
Cash assistance and Medi-Cal to low-income disabled individuals (all ages).

800 772-1213

every child counts
FIRST5 ALAMEDA COUNTY
First 5 Alameda County generously funded updates.

Alameda County Medical Home Project: Phone/Fax (510) 540-8293

ACMHP_CR_0415.pdf

Agencies	Eligibility	Income Requirements	Services
Family Resource Network (FRN) (510) 547-7322	• Ages 0 up to 22 years • All families and/or caregivers of special needs children residing in Alameda County	• No income limits	• Parent to parent support for families of children with special health and developmental needs including children who are at "high risk" for delays • Free information and referral services to generic agencies • Family navigation of services • Quarterly newsletter • Resource library • Training & Advocacy

Special Education Local Plan Area (SELPA)
 	
See reverse side for individual SELPA #s.
 	
See Rx Pad for school district #s. One must write district to request assessment to determine eligibility.
	• Ages 0 up to 22 years
	• District assessment process determines eligibility
	• Disability categories: autism; deafness; deaf-blind; emotional disturbance; hearing impairment; mental retardation; muliple disability; orthopedic impairment; other health impairment; specific learning disability; speech/language impairment; traumatic brain injury; visual impairment, including blindness
	• **AND** who need special education to benefit from public education
	• Early Start eligible: Solely Low Incidence (SLI) - hearing, visual and orthopedic impairments
		• No income limits
		
		• Free and Appropriate Public Education (FAPE), at no cost to the parents, in the Least Restrictive Environment (LRE).
			• Support / Oversight of special education services delivered by local school districts
			• Individualized Education Program (IEP)
			• Specialized instruction and necessary Related Services such as:
			  • Home visits/Respite (Early Start only)
			  • Assistive Technology (AT)/services
			  • Family training, counseling
			  • Nursing assessments
			  • Hearing Screening and services
			  • Vision screening & services
			  • Health-related services at school
			  • OT & PT
			  • Psychological, Mental Health services
			  • Speech/Language services
			  • Adaptive Physical Education
			  • Transportation
			  • Others as needed (not an exhaustive list)

Regional Center of the East Bay (RCEB) (510) 618-6100 (# for ages 3 and up)	• Life Span • Developmental disabilities including retardation, cerebral palsy, epilepsy, autism	• No income limits • Family Cost Participation (FCPP) required on respite, daycare and camping (3–18) services for families over 400% of Federal Income Guidelines (FIG) [also known as Federal Poverty Level, or FPL] and whose children are ages 0 up to age 18.	• Non-medical services, mostly case-management • Family support, respite, crisis intervention, special living arrangements, community integration • Interpreter/translator, advocacy, transportation vouchers • Assessment, rehabilitation and training, treatment, therapy, prevention, special equipment (usually as payer of "last resort")
Early Start Prevention Program (510) 618-6195 (RCEB # for ages 0-3)	• 0 up to age 3 • Presenting with significant developmental delay • Diagnosed physical or mental condition that has a high probability of resulting in a developmental delay • Prevention Program assumes responsibility for 0-3 year olds who are at "high risk" for delays in development or who are referred between 24 and 35 months with a level of delay that does not meet Early Start eligibility	• For specific health care services identified In the IFSP, families are required to use their private insurance or health care service plan; Regional Center remains "payer of last resort"	• Intake / Assessment • Diagnostic services • Case management • Monitoring • Nursing • Nutritional counseling • OT & PT • Psychological services • Respite • Social Work services • Assistive devices / services • Audiology services • Family training, counseling, home visits • Some health services • Special instruction • Speech/Language services • Transportation • Vision services • Referral for generic services
County Mental Health (800) 491-9099	• Life Span • Children/Youth with full scope Medi-Cal (0 up to age 21) • Children/Youth in Healthy Families Program (0 up to age 19) • Special education referrals from schools (0 up to age 22)	• Medi-Cal or Healthy Families income limits • No income limits if referred by school system	• Outpatient assessment or psychological evaluation & referral to community practitioners • All services required of an IEP including day & residential treatment as necessary • Psychological emergency services (for a fee, if not covered by insurance
California Children Services (CCS) (510) 208-5970	• 0 up to age 21 • Children and youth with physical injuries, illness, or disabilities (see CCS diagnoses below)	• For diagnostics, PT & OT: no income requirements • For coverage of CCS condition, income less than $40,000 • If medical expenses greater than 20% family income	• Diagnostic services • High Risk Infant Program • All services which apply to condition: doctors, hospital, surgery, PT, OT, lab tests, x-rays, orthopedic & medical equipment, case management including transportation and maintenance

CCS Diagnoses:

- Heart conditions
- Neoplasms
- Blood disorders (hemophilia, sickle cell anemia)
- Respiratory system disorders (cystic fibrosis, chronic lung disease)
- Endocrine, nutritional & metabolic disorders (PKU, thyroid problems or diabetes)
- Genito-urinary system disorders (serious kidney problems)
- Gastrointestinal system disorders (biliary artesia)
- Serious birth defects (cleft lip/palate, spina bifida)
- Nervous system disorders (cerebral palsy, uncontrolled epilepsy)
- Sense organ disorders (hearing loss, loss of vision due to glaucoma or cataracts)
- Musculoskeletal & connective tissue disorders (muscular dystrophy, JRA)
- Severe disorders of the immune system (HIV)
- Disabling injuries & poisonings requiring intensive care or rehabilitation (severe brain, spinal cord injuries & burns)
- Complications of premature birth requiring an intensive level of care
- Skin & subcutaneous tissue disorders (severe hemangioma)

Alameda County Resource Referrals "Rx-pad" sample pages

Actual size samples: 5.5"W x 4.25"H

Alameda County Resource Referrals

Every child deserves a medical home.

(510) 540-8293

Referral Date: _____ DOB: _____

Patient: _____

Provider: _____

DEVELOPMENTAL SERVICES

❑ Early Start (0-3)		510 618-6195
❑ Regional Center (>3)		510 618-6100

FAMILY ASSISTANCE & SUPPORT

❑ Child Care	North County	510 658-0381
	South County	510 582-2182
	East County	925 417-8733
❑ Family Paths (Parental Stress)		800 829-3777
❑ Family Resource Network		510 547-7322
❑ Food Stamps & Housing		211
❑ Medi-Cal		888 747-1222
❑ SSI		800 772-1213
❑ WIC		888 942-9675

HEALTH SERVICES

❑ CEID - Ctr. EI on Deafness	510 848-4800
❑ CHO Audiology	510 428-3344
❑ CHO Child Development	510 428-3351
❑ CHO Speech & Language	925 979-3470
❑ CHO Speech & Language	925 979-3440
❑ UCB Optometry (Special Assess)	510 642-2020

MENTAL HEALTH

❑ ACCESS	800 491-9099

Help Me Grow (0-5)

Referrals for development, behavior and learning

❑ Linkage Line	888 510-1211

EDUCATIONAL SERVICES

❑ Alameda	510 337-7075
❑ Albany	510 559-6536
❑ Berkeley	510 644-8913
❑ Castro Valley	510 537-3000 x1200
❑ Dublin	925 828-2551x8031
❑ Emeryville	510 601-4907
❑ Fremont	510 659-2569
❑ Hayward	510 784-2611
❑ Livermore Valley	925 606-3225
❑ New Haven	510 471-1100x62616
❑ Newark	510 818-4209
❑ Oakland	510 879-8100
❑ Piedmont	510 594-2893
❑ Pleasanton	925 426-4293
❑ San Leandro	510 667-3507
❑ San Lorenzo	510 317-4761

Note: The ACMHP companion CD also contains a printable pdf file: ACMHP_RX_0815.pdf

Alameda County Resource Referrals

Every child deserves a medical home.

(510) 540-8293

Referral Date: _____ DOB: _____

Patient: _____

Provider: _____

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❑ San Lorenzo	510 317-4761

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Diagnostic Evaluation Form (Medi-Cal)
Completed by Primary Care Provider, Pediatrician or Neurologist

Information provided will be protected in accordance with HIPAA requirements and other applicable confidentiality regulations. For questions call Beacon at 855-834-5654.

Patient Information:

Patient's Last Name/First Name: _____

Patient's DOB: _____ Subscriber ID #:_____

Provider Information:

Name of Provider License/Certification Federal Tax ID# _____

Street Address _____ Zip _____

Telephone #_____ Fax #_____

Evaluation/Assessment Information: Date of Evaluation/Assessment: _____

1. Summary of Identified Behavioral Excesses and Deficits:

☐ Speech Delay	☐ Poor Eye Contact	☐ Low Social Response
☐ Low Peer Interaction	☐ Repetitive Behaviors	☐ Hyperactivity
☐ Preoccupation of Interests	☐ Stereotypic Movement	☐ Echolalia
☐ Self-Injury	☐ Aggression	☐ Elopement

☐ Other: _____

2. Is BHT/ABA Treatment Assessment Recommended? ☐Yes ☐No _____

3. Behavioral Health Diagnosis:

Primary: _____

Secondary: _____

4. Medical Diagnosis: _____

Describe any medical condition that could be causing or contributing to Autism like behavioral excesses or deficits described above: _____

_____

_____

_____

Provider Signature _____ Date:_____

Return completed Diagnostic Evaluation Form to:
Fax: 800 596-2712
Mail: Beacon Autism Services 5665 Plaza Dr., Suite 400 Cypress, CA 90630

Beacon Health Strategies
Primary Care Provider (PCP) Referral Form

Date: _____ **PCP Name**: _____ **Phone #**: _____

Member Name: _____ **Member ID #:** _____ **DOB:** _____

Language: _____ **Phone #'s:** _____ ; _____

PCP Request (one request per referral form)

☐**PCP Decision Support: Request a telephone consultation** with a Beacon psychiatrist to provide decision support related to member diagnostic and medication clarification or other clinical decision supports.
**Include medication list and last 2 PCP Progress Notes for Psychiatrist review before phone consult with PCP.
Fax: ***866.422.3413*** *OR secure email: medi-calreferral@beaconhs.com*

☐**Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Beacon's network of providers when their needs are outside the PCP scope of practice. Beacon can coordinate member care with county mental health.
** For exchange of information *back to the PCP*, include signed member Consent to Release of Information.
Fax: ***866.422.3413*** *OR secure email: medi-calreferral@beaconhs.com*

☐**Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services:** Specialty services for youth under 21 years old with established diagnosis of Autism Spectrum Disorder (ASD).
**Include Progress Note with diagnosis of ASD and physician order requesting ABA services.
Fax to: ***800.596.2712***

☐ **Referral for Care Management:** Local behavioral health care coordination services to help link members to mental health providers, support their transition between levels of care, or engage members with history of non-compliance and link them to community support services.
** For exchange of information *back to the PCP*, include signed member Consent to Release of Information.
Fax: ***877- 768-2306*** *OR email: cmc_aah@beaconhs.com*

Request Reason (check all that apply):

☐Depression	☐Anxiety	☐Poor self-care due to mental health
☐Isolation	☐Delusional	☐Auditory/Visual hallucinations
☐Trauma	☐Violence/Abuse	☐Cognitively Impaired (or cognitive impairment)
☐Substance use type: _____		☐Other BH Diagnosis: _____

☐Other BH symptoms: _____

Medical Diagnosis: _____

Medications (list below or send medication list with this form):

_____

_____

Other known barriers to member adherence to medical care: _____

_____

Motivation for Services (check all that apply):
☐Member (or guardian) has been informed of referral to Beacon Health Strategies
☐Member wants services for self (or dependent)
☐If applicable, Patient has completed a PHQ-2/PHQ-9. Score _____

Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

Member Consent to Release Confidential Information

I, _____ give permission to _____
(Member Name) (Behavioral Health Provider)
and my Primary Care Physician _____ to share information about my
(Primary Care Physician)
diagnosis and / or treatment related to substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.

_____ _____
Member/Guardian/Authorized Representative Date

_____ _____
Witness Date

Member Refusal to Release Confidential Information

I, _____ **DO NOT** give permission to _____
(Member Name) (Behavioral Health Provider)
and my Primary Care Physician _____ to share information about my
(Primary Care Physician)
diagnosis and / or treatment related to substance abuse, mental health, or medical history, including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

_____ _____
Member/Guardian/Authorized Representative Date

_____ _____
Witness Date

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.

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ALAMEDA COUNTY
Behavioral Health Care Services

ALCOHOL, DRUG & MENTAL HEALTH SERVICES
MARYE L. THOMAS, M.D., DIRECTOR

Fax completed form to: (510) 383-2820
Radawn Alcorn, TAY System of Care (510) 567-8199 or ralcorn@acbhcs.org

PLEASE ATTACH ADDITIONAL CLINICAL INFORMATION TO THIS FORM – PSYCH EVALS – HOSPITAL INTAKES- DISCHARGE NOTES AND ANY OTHER RELEVENT DOCUMENTATION. THANK YOU.

CLIENT NAME: _____

BIRTH DATE: _____ AGE_____ REFERRAL DATE:_____

SSN: _____ CLIENT #: _____

ADDRESS: _____

_____

PHONE NUMBER: _____

REFERRED BY

YOUR NAME: _____

AGENCY:_____

PHONE: _____

FAX: _____

CLIENT CONTACT INFORMATION: _____

WHY REFERRING TO TAT?

_____

_____

_____

_____

_____

CURRENT DIAGNOSIS & SUPPORTING SYMPTOMS- PLEASE INCLUDE DIAGNOSIS ON ALL AXES AND GAF:

AXES I: _____ AXES IV: _____

AXES II: _____ AXES V: _____

AXES III: _____ GAF: _____

LIST MEDICATION & COMPLIANCE:

_____

_____

_____

PRESCRIBING MD: _____ NEXT APPOINTMENT DATE: _____

HOSPITALIZATION HISTORY: (PLEASE ATTACH ADDITIONAL PAGES IF NEEDED)

DATE: _____ REASON:_____

DATE:_____ REASON:_____

DATE:_____ REASON:_____

SUBSTANCE ABUSE: (DRUG OF CHOICE? HOW LONG? FAMILY HISTORY?)

_____

_____

_____

SELF-HARM HISTORY:

_____

_____

_____

CRIMINAL/VIOLENCE HISTORY:

_____

_____

_____

WHAT HAS BEEN DONE TO HELP TRANSITION CLIENT TO ADULT MENTAL HEALTH SERVICES?

_____

_____

_____

CURRENT LIVING SITUATION (IF ENDING, WHY & WHEN? WHERE WILL CLIENT LIVE IN NEXT 6 MONTHS?):

_____

_____

_____

EDUCATION ❑ GRADE COMPLETED _____ ❑ HIGH SCHOOL DIPLOMA ❑ GED ❑ CERTIFICATE OF COMPLETION

❑ COLLEGE DEGREE: _____ ❑ OTHER CERTIFICATIONS/ TRAINING: _____

WHAT ARE THE CLIENT'S EDUCATION, VOCATION AND/OR CAREER GOALS?

_____

_____

_____

HAS THE CLIENT BEEN IN FOSTER CARE? ❑ YES ❑ NO

JURISDICTION: _____ CWW: _____

PLEASE DESCRIBE THE CLIENT'S FOSTER CARE CIRCUMSTANCES AND EXPERIENCE:

_____

_____

_____

CURRENT LEVEL OF SOCIAL/INTELLECTUAL FUNCTIONING & DAILY LIVING SKILLS:

_____

_____

_____

STRENGTHS, SUPPORTS & FAMILY INVOLVEMENT:

_____

_____

_____

STATUS OF BENEFITS & APPLICATION FOR ADULT SSI:

_____

_____

DOES THE CLIENT HAVE INSURANCE? ❑ YES ❑ NO

IF SO, WHAT KIND? ❑ MEDICAL ❑ PRIVATE: _____ ❑ OTHER: _____

WHAT AGENCIES AND OTHER RESOURCES ARE INVOLVED? ❑ THP/ THP + ❑ CASE MGMT: _____

❑ HOUSING: _____ ❑ MENTAL HEALTH: _____

❑ OTHER: _____

WHAT DOES THE CLIENT WANT AND NEED:

❑ HOUSING ❑ GROUPS ❑ MEDICATION SUPPPORT ❑ CASE MANAGEMENT

❑ VOCATIONAL TRAINING ❑ TO CONTINUE EDUCATION ❑ OTHER _____

_____

WHAT IS THE CURRENT DISCHARGE PLAN? _____

_____

_____

THE TAT COMMITTEE MAY CALL FOR MORE INFORMATION OR MAKE AN APPOINTMENT FOR YOU TO PRESENT TO THE COMMITTEE ON WEDNESDAYS, BETWEEN 10:30 A.M. AND 12 NOON. PLEASE ATTACH ANY SUPPORTING DOCUMENTATION YOU MAY HAVE ON THE CLIENT'S MENTAL HEALTH HISTORY (I.E. PSYCHOSOCIAL ASSESSMENTS, PSYCHOLOGICAL EVALUATIONS, DISCHARGE SUMMARIES, ETC. PLEASE DISCUSS WITH RADAWN ALCORN, LCSW THE BENEFITS OF INVITING OTHER PROFESSIONALS CURRENTLY PROVIDING SERVICES TO THE CLIENT, I.E. STAFF FROM SOCIAL SERVICES, AB3632, PROBATION, REGIONAL CENTERS. BE PREPARED TO DISCUSS A BREIF PSYCHOLOGICAL HISTORY, EDUCATIONAL STATUS/ AB 3632 HISTORY, DEVELOPMENTAL ISSUES, THE CLIENT'S LIFE GOALS, AND CURRENT TREATMENT AND DISCHARGE PLANS. THANK YOU.

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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 ☐ Male ☐ 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? ☐ Yes ☐ No	If yes, what is the applicant's Medi-Cal number?	Is there a share-of-cost? ☐ Yes ☐ No	If yes, what amount do you pay per month? $

20. Is the applicant enrolled in the Healthy Families program? ☐ Yes ☐ No	If yes, what is the name of the plan?

21 Does the applicant have other health insurance? ☐ Yes ☐ No	If yes, what is the name of the insurance plan or company?

Type of insurance plan or company

☐ Preferred Provider (PPO) ☐ Health Maintenance Organization (HMO) ☐ Other:_____

22. Does the applicant have dental insurance? ☐ Yes ☐ No	23. Does the applicant have vision insurance? ☐ Yes ☐ 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.

WHAT IS CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM? CCS is a program which treats children with certain physical limitations and diseases. The program is paid for by California taxpayers and offers medical care to children whose families cannot afford all or part of needed care.

WHO QUALIFIES FOR CCS? The program is open to anyone who: (1) is under 21 years of age; (2) has a physical limitation or disease that is covered by CCS; (3) is a permanent resident of California; and (4) has a family income of less than $40,000 reported as Adjusted Gross Income on the state tax form; or whose out-of-pocket medical expenses for a child who qualifies is expected to be more than 20 percent of the family income. There is no income limit for CCS medical therapy unit services, the High Risk Infant Follow-up Program, or the Diagnostics Program.

HOW DOES A CHLD GET CCS SERVICES? The CCS agency in the county where a child lives approves services for a child. Such requests or referrals may be made by anyone including the family, school or public health nurse, family doctor or physician specialist. It is important that referrals be made to CCS as early as possible since CCS does not pay for any medical care that is provided before the date the referral is made. A family must also apply for CCS. Once the family applies, CCS decides whether the child meets the medical, residential, and financial qualifications for CCS.

WHAT MUST THE APPLICANT OR FAMILY DO TO QUALIFY FOR CCS? To obtain CCS for the qualifying disease or limitation families must **1) Complete an application form and return it to CCS by the date given or CCS services will not be authorized.** This also applies to children with Medi-Cal for certain benefits which Medi-Cal does not cover. The completed application form must be received within 50 days of the mailing date of the first Application Request letter. If the application is not received within this period, CCS coverage will not begin until the date the application is received. **2) Provide CCS with all other information requested so that CCS can decide whether the family qualifies.** If all needed information is not provided, the case may not be opened. **3) Apply to Medi-Cal if CCS decides that a family's income qualifies for the Medi-Cal program.** If a family qualifies for Medi-Cal the child is also covered by CCS which approves services, but payment is made by Medi-Cal. CCS may pay for services which are not covered by Medi-Cal and the family benefits from both programs. In this way, limited CCS funds can be stretched to cover many more children.

PRIVACY NOTIFICATION. The California Children's Services agency in the county where you live is asking for the information on this form. The information asked by CCS is required except where the form shows you have a choice. If you do not provide the required information, your child's application is incomplete and CCS may not be able to open the case. CCS may share the information on the form with the State Department of Health Services and the county in which you live. It will not be shared with anyone else without a signed authorization by parents or legal guardian of the child to release information. You have a right to see your application and CCS records concerning you or your child. If you wish to see these records contact your county CCS agency. By law, the information you give to CCS is kept by the program (Section 428 et seq., of the California Health and Safety Code). California law also requires that families applying for services shall be given the above information (Civil Code Section 1798.17).

YOUR APPEAL RIGHTS: You have the right to appeal decisions made by CCS in accordance with California Code of Regulations, Title 22, Chapter 13, Section 42702–42703.

For information on the appeal process, contact the Alameda County CCS office at (510) 208-5970.

SOLICITUD PARA DETERMINAR SI EL SOLICITANTE PUEDE PARTICIPAR EN EL PROGRAMA CCS

Esta solicitud debe ser completada por el padre, el tutor o el solicitante (si cumplió los 18 años de edad o es un menor de edad emancipado) para determinar si el solicitante cumple con los requisitos para recibir servicios y beneficios de CCS. El término **"solicitante"** significa el niño, la persona de 18 años de edad o más o el menor de edad emancipado para el que se solicitan los servicios. Para obtener instrucciones sobre cómo completar este formulario, consulte la página 4. Escriba a máquina o claramente en letras de molde.

A. Información sobre el solicitante

1. Nombre del solicitante [apellido] [nombre] [segundo nombre]	Nombre en el certificado de nacimiento (si es diferente)	Algún otro nombre por el que se conoce al solicitante

2. Fecha de nacimiento (mes, día, año) _____ / _____ / _____	3. Lugar de nacimiento, condado y estado	País, si nació fuera de EE.UU.

4. Dirección del solicitante (número y calle) (no usar casilla postal)	Ciudad	Condado	Código postal

5. Género ☐ Masculino ☐ Femenino	6. Raza/ etnia	7. Número del seguro social ***(optativo)*** __ __ __ - __ __ - __ __ __ __

8. ¿Cuál es el problema o la discapacidad del solicitante que se sospecha que cumple con los requisitos de CCS?

9. Nombre completo del médico del solicitante	10. Número de teléfono del médico ( )

B. Información sobre el padre o tutor (los solicitantes de 18 años de edad o mayores o los menores emancipados saltean los números 11 y 13).

11. Nombre(s) completo(s) del/de los padre(s) o tutor(es)	12. Nombre de la madre (si no se identificó en 11)	Apellido de soltera

13. Dirección (número y calle) (no usar casilla postal)	Ciudad	Condado	Código postal

14. Dirección postal (si no es la misma que la del 13)	Ciudad	Código postal

15. Nº de teléfono diurno ( )	16. Nº de teléfono nocturno ( )	17. Nº para mensajes telefónicos ( )	18. ¿Qué idioma se habla en su casa?

C. Información sobre el seguro de salud

19. ¿Tiene Medi-Cal el solicitante? ☐ Sí ☐ No	Si tiene, ¿cuál es el número de Medi-Cal del solicitante?	¿Comparte el costo? ☐ Sí ☐ No	Si lo comparte, ¿cuánto paga por mes? $

20. ¿Está inscrito el solicitante en el programa Healthy Families? ☐ Sí ☐ No	Si lo está, ¿cómo se llama el plan?

21. ¿Tiene el solicitante otro seguro de salud? ☐ Sí ☐ No	Si lo tiene, ¿cómo se llama el plan o la compañía de seguros?

Tipo de plan o compañía de seguros
☐ Proveedor Preferente (PPO) ☐ Organización para el Mantenimiento de la Salud (HMO) ☐ Otro:_____

22. ¿Tiene seguro dental el participante? ☐ Sí ☐ No	23. ¿Tiene seguro de la vista el solicitante? ☐ Sí ☐ No

D. Certificación (Coloque sus iniciales y firme a continuación. Su firma autoriza al programa CCS a proceder con esta solicitud).

___ Solicito el programa CCS para determinar el cumplimiento de requisitos para obtener servicios y beneficios. Entiendo que completar esta solicitud no garantiza la aceptación del solicitante en el programa CCS.

___ Doy permiso para que se verifique mi dirreción, información sobre la salud u otras circunstancias que se requieran para determinar el cumplimiento de requisitos para recibir servicios y beneficios CCS.

___ Certifico que he leído y comprendo la información o que me la han leído.

___ También certifico que la información que escribí en este formulario es verdadera y correcta.

Firma de la persona que llenó la solicitud	Relación con el solicitante	Fecha

Firma del testigo (sólo si la persona firmó con una marca)	Fecha

Envíe este formulario por correo a la oficina CCS de su condado. Consulte la página 6 para obtener una lista de direcciones.

¿QUE ES EL PROGRAMA DE LOS SERVIOS DE LOS NIÑOS DE CALIFORNIA (CCS)? El CCS es un programa el cual atiende niños con ciertas limitaciones fisicas y enfermedades. El programa es pagado por los contribuyentes de impuestos de California y ofrece cuidado medico a niños cuales familias no pueden pagar todo o parte del cuidado.

¿QUIEN CALIFICA PARA EL CCS? El programa esta abierto para cualquiera que: (1) es menor de 21 años de edad; (2) tiene una limitación fisica or enfermedad que es cubierta por el CCS; (3) es un recidente permanente de California; y (4) tiene un ingreso familiar de menos de $40,000 reportado come Ingreso Bruto, ajustado por el Estado en la forma de ingresos; o quien cuyos gastos medicos fuera de su bolsa para el niño que califica es esperado que sea mas del 20 por ciento del ingreso de la familia. No hay limite en su ingreso economico familiar para los servicios del CCS en el programa unidad de terapia medica, el programa para bebes de alto riesgo o el programa de diagnostico.

¿COMO PUEDE EL NIÑO RECIBIR SEVICIOS DEL CCS? La agencia del CCS en el condado en el cual el niño vive es el que aprueva los servicios para el niño. Dichos pedidos o referencias, pueden ser hechas por cualquier persona incluyendo la familia, escuela o enfermera de salud publica, el doctor familiar, o un doctor especialista. Es muy importante que las referencia sean hechas al CCS lo mas temporano posible ya que el CCS no paga por ningun cuidado medico que fue rendido antes de la fecha que la referencia fue hecha. Una familia tambien tiene que aplicar para el CCS. Una vez la familia aplica, el CCS decide si el niño satisface los requisitos para el CCS, medicamente y financieramente.

¿QUE ES ESPERADO DEL CANDIDATO O DE LA FAMILIA? Para obtener fondos de CCS para la condición elegible lo mas pronto posible, es esencial que: **(1) La aplicación sea completa y regresada dentro del tiempo formulado especificado. Sin la aplicación fimada, CCS es incapaz de proceder con el proceso de determinación de la elegibilidad. Autorizaciónes para servicios no pueden ser repartidos a menos que elegibilidad sea confirmada.** Esto tambien aplica para niños que tienen Medi-Cal para algunos beneficios los cuales Medi-Cal no cubre. La aplicación comletada tiene que ser recibida antes de 50 dias de la fecha en que la aplicación fue enviada de la primera carta. Si la aplicación no es recibida durante este periodo, el CCS no comenzara a cubrir hasta la fecha en que la aplicación es recibida. **(2) Proveerle al CCS con toda la información requerida para que el CCS pueda decidir si la familia califica.** Si toda la información necesitada no es recivida, el caso talvez no sera abierto. **(3) Aplicar para Medi-Cal si el CCS decide de que el ingreso economico de la familia califica para el programa del Medi-Cal.** Si la familia califica para el Medi-Cal, el niño tambien es cubierto por el CCS el cual aprueba los servicios, pero el pago es hecho por el Medi-Cal. El CCS talvez pague por servicios que no son cubiertos por el Medi-Cal, y la familia se beneficia de ambos programas. De esta manera, los fondos limitados del CCS son estrechados para cubir muchos mas niños.

NOTIFICACION PRIVADA: La agencia de los Servicios de los Niños de California en el condado en el que usted vive esta preguntando por la información en esta forma. La información pedida por el CCS es requerida excepto donde la forma senala de que usted tiene elección. Si usted no provee la información requerida, la aplicación de su niño estara incompleta y el CCS talvez no podra abrir el caso. El CCS talvez comparta la información en esta forma con el Departamento del Estado de los servicios de la Salud y el condado en el que usted vive. No sera compartido con nadie mas sin una autorización firmada por el padre o guardian legal del niño antes de dar cualquier información. Usted tiene el derecho de ver su aplicación y las libretas del CCS concerniente a usted y su niño. Si usted desea ver estas libretas, pongase en contacto con la Agencia del CCS de su condado. Por ley, la información que usted da al CCS es guardada por el programa (Sección 428 et seq., de la Salud de California y Código de Seguridad). La ley de California tambien requiere de que las familias aplicando para los servicios se le dara la información de arriba (Sección del Código Civil 1798.17).

SUS DERECHOS DE APELACIÓN: Usted tiene el derecho para apelar las decisiones hechas por CCS, de acuerdo con el Código de California de Regulaciones, Titule 22, Capítulo 13, Sección 42702–42703.

Para la información sobre el proceso de apelación, llame al Condado de Alameda a la oficina de CCS al (510) 208-5970.

CALIFORNIA CHILDREN'S SERVICES (CCS)
1000 Broadway, Suite 500
Oakland, CA 94607
Phone: 510-208-5970
Fax: 510-267-3254

REFERRAL FORM/REQUEST FOR SERVICE

CCS # County Transfer Yes ☐ No ☐

NAME OF CHILD - LAST	BD: MONTH DAY YEAR		DATE REFERRED	DATE ELIGIBLE (for CCS only)
FIRST	SSN		LANGUAGE	FOSTER CHILD YES ☐ NO ☐
AKA:	SEX M ☐ F ☐	ETHNICITY	BIRTHPLACE	CA RESIDENT YES ☐ NO ☐
ADDRESS - NUMBER - STREET	CITY/ZIP		HOME PHONE ( ) ALT PHONE ( )	WORK/MESSAGE ( )
NAME OF MOTHER	ADDRESS		HOME PHONE	WORK PHONE
			SSN:	
NAME OF FATHER	ADDRESS		HOME PHONE	WORK PHONE
			SSN:	
NAME OF LEGAL CUSTODIAN	ADDRESS		RELATION TO CHILD	
PRIMARY DX	PCP		HOSPITAL NAME & MEDICAL RECORD NUMBER	
CCS SIBLINGS – NAME AND DOB				
MEDI-CAL NUMBER	INSURANCE: YES ☐ NO ☐		INSURANCE CO:	
	HMO: YES ☐ NO ☐		SUBSCRIBER:	
			POLICY #:	
MEDI-CAL MANAGED CARE PLAN: DIAGNOSES/SERVICES REQUESTED				
PREFERRED SPECIALIST:			PHONE #:	

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REFERRAL FORM

FAMILY
RESOURCE
NAVIGATORS
OF ALAMEDA COUNTY

Date: _____

I would like a Parent Health Liaison from Family Resource Network to contact me.
My primary care provider has my permission to release the following information to you:

❑ My name: _____ ❑ Relationship to child: _____

❑ Address: _____

City: _____ Zip: _____

❑ Home phone: ( ) _____ ❑ Work phone: ( ) _____

❑ Best time to call: _____ ❑ Primary language spoken: _____

❑ Child's name: _____ ❑ Birthdate: _____

❑ A description of needs or diagnosis and reason for referral: _____

_____

_____

_____ _____

Parent/Guardian's signature Date

_____ ( ) _____

Referring Provider (please print) Fax number

FRN RESPONSE:

Thank you for your referral. We have contacted the family and they have asked to be:

❑ Added to our mailing list.
❑ Assisted with access to: ❑ CCS ❑ RCEB ❑ ACCESS ❑ SSI ❑ Other: _____
❑ Connected to our family support services.
❑ Counseled in their primary language.
❑ Guided in their IFSP/IEP preparation.
❑ Provided with information about rights and responsibilities.
❑ We were not able to reach the family.

Comments: _____

_____

_____ _____

FRN Staff Date

291 Estudillo Avenue San Leandro, CA 94577 TEL (510)547-7322 FAX (510) 296-5768 TDD (510) 658-2307

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

Permissions for Use of the M-CHAT-R/F™

The Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F; Robins, Fein, & Barton, 2009) is a 2-stage parent-report screening tool to assess risk for Autism Spectrum Disorder (ASD). The M-CHAT-R/F is available for free download for clinical, research, and educational purposes. Download of the M-CHAT-R/F and related material is authorized from www.mchatscreen.com.

The M-CHAT-R/F is a copyrighted instrument, and use of the M-CHAT-R/F must follow these guidelines:

(1) Reprints/reproductions of the M-CHAT-R must include the copyright at the bottom (© 2009 Robins, Fein, & Barton). No modifications can be made to items, instructions, or item order without permission from the authors.

(2) The M-CHAT-R must be used in its entirety. Evidence indicates that any subsets of items do not demonstrate adequate psychometric properties.

(3) Parties interested in reproducing the M-CHAT-R/F in print (e.g., a book or journal article) or electronically for use by others (e.g., as part of digital medical record or other software packages) must contact Diana Robins to request permission (DianaLRobins@gmail.com).

(4) If you are part of a medical practice, and you want to incorporate the first stage M-CHAT-R questions into your own practice's electronic medical record (EMR), you are welcome to do so. However, if you ever want to distribute your EMR page outside of your practice, please contact Diana Robins to request a licensing agreement.

Instructions for Use

The M-CHAT-R can be administered and scored as part of a well-child care visit, and also can be used by specialists or other professionals to assess risk for ASD. The primary goal of the M-CHAT-R is to maximize sensitivity, meaning to detect as many cases of ASD as possible. Therefore, there is a high false positive rate, meaning that not all children who score at risk will be diagnosed with ASD. To address this, we have developed the Follow-Up questions (M-CHAT-R/F). Users should be aware that even with the Follow-Up, a significant number of the children who screen positive on the M-CHAT-R will not be diagnosed with ASD; however, these children are at high risk for other developmental disorders or delays, and therefore, evaluation is warranted for any child who screens positive. The M-CHAT-R can be scored in less than two minutes. Scoring instructions can be downloaded from http://www.mchatscreen.com. Associated documents will be available for download as well.

Scoring Algorithm

For all items except 2, 5, and 12, the response "NO" indicates ASD risk; for items 2, 5, and 12, "YES" indicates ASD risk. The following algorithm maximizes psychometric properties of the M-CHAT-R:

LOW-RISK: **Total Score is 0-2**; if child is younger than 24 months, screen again after second birthday. No further action required unless surveillance indicates risk for ASD.

MEDIUM-RISK: **Total Score is 3-7**; Administer the Follow-Up (second stage of M-CHAT-R/F) to get additional information about at-risk responses. If M-CHAT-R/F score remains at 2 or higher, the child has screened positive. Action required: refer child for diagnostic evaluation and eligibility evaluation for early intervention. If score on Follow-Up is 0-1, child has screened negative. No further action required unless surveillance indicates risk for ASD. Child should be rescreened at future well-child visits.

HIGH-RISK: **Total Score is 8-20**; It is acceptable to bypass the Follow-Up and refer immediately for diagnostic evaluation and eligibility evaluation for early intervention.

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

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**For Example**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (**For Example**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**For Example**, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**For Example**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**For Example**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**For Example**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**For Example**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**For Example**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**For Example**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (**For Example**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**For Example**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**For Example**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**For Example**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**For Example**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**For Example**, being swung or bounced on your knee)	Yes	No

Website http://www.mchatscreen.com/Official_M-CHAT_Website_files/M-CHAT-R_F.pdf
Sources http://www.dbpeds.org/media/mchat.pdf (Developmental Behavioral Pediatrics Online)

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

M-CHAT-R™

Por favor conteste las siguientes preguntas teniendo en cuenta el comportamiento que su hijo/a presenta usualmente. Si ha notado cierto comportamiento algunas veces, pero no es algo que hace usualmente, por favor conteste **no**. Conteste cada una de las preguntas, marcando con un círculo, la palabra **sí** o **no** como respuesta. Muchas gracias.

1. ¿Si usted señala un objeto del otro lado del cuarto, su hijo/a lo mira? **(POR EJEMPLO** ¿Si usted señala un juguete o un animal, su hijo/a mira al juguete o al animal?)	Sí	No
2. ¿Alguna vez se ha preguntado si su hijo/a es sordo/a?	Sí	No
3. ¿Su hijo/a juega juegos de fantasía o imaginación? (**POR EJEMPLO** finge beber de una taza vacía, finge hablar por teléfono o finge darle de comer a una muñeca o un peluche)	Sí	No
4. ¿A su hijo/a le gusta treparse a las cosas? **(POR EJEMPLO** muebles, escaleras o juegos infantiles)	Sí	No
5. ¿Su hijo/a hace movimientos inusuales con los dedos cerca de sus ojos? **(POR EJEMPLO** ¿Mueve sus dedos cerca de sus ojos de manera inusual?)	Sí	No
6. ¿Su hijo/a apunta o señala con un dedo cuando quiere pedir algo o pedir ayuda? **(POR EJEMPLO** señala un juguete o algo para comer que está fuera de su alcance)	Sí	No
7. ¿Su hijo/a apunta o señala con un dedo cuando quiere mostrarle algo interesante? (**POR EJEMPLO** señala un avión en el cielo o un camión grande en el camino)	Sí	No
8. ¿Su hijo/a muestra interés en otros niños? (**POR EJEMPLO** ¿mira con atención a otros niños, les sonríe o se les acerca?)	Sí	No
9. ¿Su hijo/a le muestra cosas acercándoselas a usted o levantándolas para que usted las vea, no para pedir ayuda sino para compartirlas con usted? (**POR EJEMPLO** le muestra una flor, un peluche o un camión/carro de juguete)	Sí	No
10. ¿Su hijo/a responde cuando usted le llama por su nombre? (**POR EJEMPLO ¿**Cuando usted lo llama por su nombre: lo mira a usted, habla, balbucea, o deja de hacer lo que estaba haciendo?)	Sí	No
11. ¿Cuándo usted le sonríe a su hijo/a, él o ella le devuelve la sonrisa?	Sí	No
12. ¿ A su hijo/a le molestan los ruidos cotidianos? (**POR EJEMPLO** ¿Llora o grita cuando escucha la aspiradora o música muy fuerte?)	Sí	No
13. ¿Su hijo/a camina?	Sí	No
14. ¿Su hijo/a le mira a los ojos cuando usted le habla, juega con él/ella o lo/la viste?	Sí	No
15. ¿Su hijo/a trata de imitar sus movimientos? (**POR EJEMPLO** decir adiós con la mano, aplaudir o algún ruido chistoso que usted haga)	Sí	No
16. ¿Si usted se voltea a ver algo, su hijo/a trata de ver que es lo que usted está mirando?	Sí	No
17. ¿Su hijo/a trata que usted lo mire? (**POR EJEMPLO** ¿Busca que usted lo/la halague, o dice “mirame”?)	Sí	No
18. ¿Su hijo/a le entiende cuando usted le dice que haga algo? (**POR EJEMPLO** ¿Su hijo/a entiende “pon el libro en la silla” o “tráeme la cobija” sin que usted haga señas?)	Sí	No
19. ¿Si algo nuevo ocurre, su hijo/a lo mira a la cara para ver cómo se siente usted al respecto? (**POR EJEMPLO ¿**Si oye un ruido extraño o ve un juguete nuevo, se voltearía a ver su cara?)	Sí	No
20. ¿ A su hijo/a le gustan las actividades con movimiento? (**POR EJEMPLO** Le gusta que lo mezan/columpien, o que lo haga saltar en sus rodillas)	Sí	No

Regional Center of the East Bay
Process for Eligibility Determination for the Early Start Program
Effective January 1, 2015

Below is the process for referrals that will be processed for RCEB Early Start eligibility determination beginning January 1, 2015 using the newly restored eligibility criteria effective as of that date:

1. Medical records are needed and should be included (as much as possible) with referrals of all children. RCEB is required to complete health status reviews as part of eligibility determination for every child.

2. For children presenting with biomedical risk factors, medical records should identify those risk factors. This documented verification supports the referral related to biomedical risk factors.

3. For children previously referred and found not eligible using 2009-2014 eligibility criteria (with delays in 33 to 49% range) less than 6 months ago, eligibility evaluations need to occur again for all who want to be evaluated again using the eligibility criteria effective January 1, 2015.

4. At time of referral, child should be at least 3 months from turning age 3. (This is to provide time to evaluate the child, and if s/he is eligible, identify appropriate available supports as well as begin the transition process.)

5. There should be an indication whether parents have or have not followed up on recommendations that were previously identified. (If parents can't find their previous evaluation report; with notice, RCEB can provide another copy of the evaluation report to the parents.)

6. There should be an indication of referral to the medical insurance provider, including Medi-Cal, and the status of the referral. (The parents of children previously referred to RCEB should have begun this process during time of first referral to Early Start, so there should have been some response and possibly some support for some children from the medical insurer related to delay concerns by the time of a new referral to Early Start.) In cases where assessment by insurer is delayed beyond 45 days, Regional Center should be alerted as the "payor of last resort" so that they can commence services while waiting for insurance to commence.

7. Help Me Grow can provide support and community resources while insurance coverage is being determined. They can also help navigate family back to RCEB.

Information from Evelyn Hoskins, Associate Director of Federal Programs
Regional Center of East Bay
12/29/14; revised MKM 3/18/15

Regional Center *of the* East Bay Supporting Alameda and Contra Costa Counties

Early Start Referral RCEB Intake Referral Line 510-618-6195; Fax 510-618-7763, Attn: EI Intake

REFERRAL SOURCE: (Name of agency or individual) _____ Phone_____

CONSENT: Verbal or written consent by Parent / Legal Guardian is required prior to this referral.
Referral cannot be processed if this is not completed.

1. _____ Verbal consent has been obtained from parent / legal guardian for referral of child to: The Early Start Program at Regional Center of the East Bay and/or LEA, and if eligible, they agree to participate.

OR

2. _____ I hereby give consent for my child to be referred to The Early Start Program at Regional Center of the East Bay and/or LEA, and if eligible, I agree to participate. I also consent to the exchange of verbal or written information between the referral source and RCEB, and/or LEA to gather information needed for intake.

3. _____ As parent or individual legally responsible for this child, I hereby give consent for the information gathered for intake referral purpose to be shared with the qualified specialists evaluating to determine eligibility for Early Start services.

Parent / Legal Guardian Signature _____ *Signature* _____ *Date*

Referral Form Completed By _____ *Signature* _____ *Date*

_____ *Title* _____ *Phone*

Person giving info _____ Relation to child _____ Phone _____

Internal Use Only
Referred to
☐ RCEB
☐ SELPA:
☐ **Transition ASAP [children 30+ months]**

Attempts to contact Phone message:
Final attempt letter sent:

Child's Name _____ *Last* _____ *First* _____ *Middle* AKA _____

☐ F ☐ M DOB _____ SSN _____ Ethnicity _____

Student # _____ District/SELPA _____

Lives with ☐ Parent ☐ Legal Guardian ☐ Foster Family ☐ Other _____

Name _____

Address _____

Phone _____ *Home Phone* _____ *Work Phone* _____ *Cell Phone*

E-mail _____ Best time to call: _____

Other Contact Person
(Name / Relationship to Family) _____

Address _____ Phone _____

If Child is a Court Dependent, Children & Family Services Worker's Name & ID # _____

Agency Address _____

Phone _____ Fax Phone # _____

If foster child: Who holds educational rights? _____
If not parents, have birth parents' educational rights been terminated or limited? ☐ Yes* ☐ No
* Please provide written documentation

Birth parent: Name _____ Phone _____

Address _____

Language(s) spoken in Child's Home (%) _____ Interpreter Needed? ☐ Yes ☐ No
Does family have interpreter? ☐ Yes ☐ No Name: _____Phone_____

Birth Status:
Vaginal ____
C-Section ____
Any Complications:

_____

_____

_____

MEDICAL & BIRTH INFORMATION

Birth Weight _____ Gestational Age _____ Apgars _____

Hospital; Born: _____ Transferred to: _____

Birthplace *(city & state)* _____

Hospital Days _____ Discharge Date _____ Medical Insurance? ☐ Yes ☐ No

Pediatrician _____ Phone _____

Insurer _____ Medical Record # _____

Current or Prior Services & Agency child is involved with

_____

Documents Requested : _____

Submit the following relevant documents for referred child; [X]:only if attached.

☐ Birth / Discharge Summary ☐ Current Medical Reports ☐ Genetic Report ☐ Court dependency report ☐ Surrogate parent documentation

☐ Developmental Report ☐ Speech, OT, or PT Evaluation ☐ Verification of Adoption Status

Statement of Need: (please explain developmental needs)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

EARLY START ELIGIBILITY CRITERIA. [determined via evaluation] Please check appropriate box. Please explain under Statement of Need [above].

1. _____ INFANT WITH ESTABLISHED RISK CONDITION **resulting in developmental disability**. (i.e. Down Syndrome, Cerebral Palsy, Intellectual Disability, Autism, Epilepsy)
2. _____ EXHIBITING SIGNIFICANT DEVELOPMENTAL DELAY
3. _____ ***(A)*** At high risk for developmental delay or disability, but have yet to manifest delays (due to multiple risk factors)- identify below

MEDICAL RISK FACTORS

	Prematurity less than 32 weeks gestation and/or low birth weight of less than 1500 gm.		Central nervous system infection.
	Assisted ventilation for 48 hours or longer during the first 28 days of life.		Biomedical insult, including but not limited to: injury, accident or illness which may seriously or permanently affect developmental outcome.
	Small for gestational age: below the third percentile on the National Center for Health Statistics growth charts.		Multiple congenital disorders which may affect developmental outcome.
	Asphyxia neonatorum associated with a 5-min Apgar score of 0 to 5.		Prenatal exposure to known teratogens.
	Severe and persistent metabolic abnormality, including but not limited to: Hypoglycemia, acidemia, and hyperbilirubinemia in excess of the usual Exchange transfusion level		Prenatal substance exposure, positive infant neonatal toxicology screen, or symptomatic neonatal toxicity or withdrawal.
	Neonatal seizures or non-febrile seizures during the first three years of life		Clinically significant failure to thrive, including but not limited to: weight persistently below the third percentile for age on standard growth charts, or less than 85% of the ideal weight for age, and/or acute weight loss or failure to gain weight with the loss of two or more major percentiles on the growth curve.
	Central nervous system lesion or abnormality.		Persistent hypotonia or hypertonia, beyond that otherwise associated with a known diagnostic condition

3. _____ ***(B)*** High Risk for a developmental disability also exists when the regional center determines that the parent of the infant or toddler is a person with a developmental disability.

Early Start Intake Coordinator _____ **Date** _____ **Phone Number** _____

Regional Center of the East Bay

Pediatrician's Referral to RCEB For Children Over Age 3

Persons who are eligible for our services over the age of 3 are persons with a developmental disability, defined as intellectual disability, cerebral palsy, epilepsy, autism, or other conditions closely related to intellectual disability or requiring treatment similar to that required by persons with intellectual disability. The condition must constitute a substantial disability, defined as significant functional limitations in three or more areas of major life activity, as determined by a regional center and as appropriate to the age of the person: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency.

To refer a child over 3, provide the family with our Intake Number (510) 618-6122

OR

After obtaining the consent required below, complete this form and fax to :

ATTENTION: INTAKE COORDINATOR/OVER 3 (510) 618-4122

CONSENT: Verbal or written consent by Parent / Legal Guardian is required prior to this referral. *Referral cannot be processed if this is not completed.*

1. _____ Verbal consent has been obtained from parent / legal guardian for referral of child to Regional Center of the East Bay

OR

2. _____ I hereby give consent for my child to be referred to Regional Center of the East Bay (RCEB) I also consent to the exchange of verbal or written information between qualified professionals from RCEB and my child's pediatrician

Parent / Legal Guardian Signature_____
Date_____

Child's Name_____D.O.B._____
Parent/Legal Guardian's Name_____
Address_____
City_____ Zip _____
Phone Numbers (Home)_____ (Cell or Work)_____
Email_____
Pediatrician's Name_____Phone Number _____
Address_____
City_____ Zip _____ E-mail_____
REASON FOR REFERRAL (see above for eligible developmental disabilities)

_____

_____

Other Information

_____

San Leandro (Main Office): 500 Davis Street, Suite 100 San Leandro CA 94577 Tel: 510 618 6100 Fax: 510.678.4100
Concord: 2151 Salvio Street, Suite 365 Concord CA 94520 Tel: 925 691.2300
Website: www.rceb.org

TO: **Primary Care Providers and Families of Children with Special Needs**
FROM: **Alameda County Medical Home Project**
RE: **California Requirement to Access Insurance First**

Child's Name:_____ DOB: _____

The changes in state policy for all Regional Centers require that **families use their health insurance first, whether public or private), for therapies**. The family must request evidence of insurance coverage (either an authorization or denial) from their insurance carrier. Regional Center will provide services for their child if the insurance decision is delayed past 45 days. Due to this change in state policy for Regional Centers, specifically Early Start Programs, we are providing simple guidelines to assist in getting services for children with special health care needs. Our goal is to ensure that all children get the evaluations and appropriate therapies necessary to address their developmental delays in a timely manner. Below are several basic recommendations to facilitate this process as well as CPT codes for commonly requested services for children with suspected developmental delay:

1) When referring to Regional Center for assessment, make a referral(s) for all areas of suspected delay to the child's private or public insurance carrier at the same time using the general ICD-9 CM **315.9 for unspecified delays in development or 299.00 (autistic disorder) or 299.80 (PDD-NOS or Asperger's).**
2) The referral to the insurance carrier should include the CPT and H codes (see below) for both the evaluation and therapeutic services needed.
3) Primary care staff should encourage families to get official notification of insurance coverage/ benefits (authorization or denial) as well as a copy of their insurance book to review the copayments and deductibles of their plan.
4) Providers and families should keep track of the dates and outcomes of referral (see below).
5) Families should be referred to Family Resource Network (510-547-7322) or their Regional Center service coordinator (510-618-6195) for questions about accessing insurance for medically necessary therapies for young children.

CPT and H Codes Relevant to Children with Possible Developmental Delays

97001 – Physical Therapy Evaluation	97530 – OT/PT Therapy Services, Direct
97003 – Occupational Therapy Evaluation	97110 – Range of motion, Flexibility, Endurance
92506 – Speech & Language Assessment	97116 – Gait Training
96116/18 – (Neuro)psychological Evaluation	97533 – Sensory Integration
92557 – Full Hearing/Audiological Evaluation	92507/08 – Individual/Group Speech Therapy
92567 – Typanometry	92526 – Feeding Therapy
92002 – Ophthalmological Exam/Evaluation	97532 – Cognitive Skills Development
92499 – Low Vision Evaluation	97755 – Assistive Technology

ABA codes: H0031 – assessment/treatment plan H2012 – direct ABA services by BCBA

Action Taken	Date
Referral to Regional Center	_____
Referral to Insurance Carrier	_____
Services Authorized	_____
Services Denied	_____
Families Informed of Decision	_____

McGrath/Wachtel/Sheehan; 12/15/09; amended 4/10/13

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SAMPLE LETTERS FOR USE BY PEDIATRIC PROVIDERS

I. Request for Comprehensive Special Education Assessment

PRACTICE LETTERHEAD

Date:

Re: [patient name]
School Name and Grade (if applicable):
Date of Birth:

Dear Special Education Director,

I am the pediatrician for [patient name] who is [X] years old and is currently enrolled at the [Elementary School] in the [X] grade. I am writing to make a referral for assessment for special education services. His/her parents/guardians, [parents' names], give full consent for this referral.

I request that [patient name] be given a comprehensive assessment by the school district in all areas of suspected disability. Please consider this a concurrent referral for assessment under Section 504 of the Rehabilitation Act. Some of the reasons are stated below.

[Insert specific examples listing all concerns such as mental health; behavioral; social/emotional; adaptive skills; motoric – gross and fine motor; intellectual; academic, attentional; health-related; speech/language; social skills; sensory; visual-motor processing and/or auditory processing; suspected learning disability, etc. For example, 'we are concerned that Joan spends 3 hours on her homework every night and still does not understand her math concepts.' Be as detailed as possible and for students with ADD/ADHD, including the medical diagnosis if made.]

I've let the parents know that after you receive this letter you will send the family an Assessment Plan in 15 calendar days for their review. I've let the family know to sign and return that form as soon as they agree or before 15 calendar days so that the assessment process can be completed and an IEP meeting held within the 60 day timeline from parent consent.

The parents request copies of the assessment reports as soon as available and at least 5 days before the IEP meeting to enable them to meaningfully participate in the IEP process. [Include email here if a family wants electronically.] Thank you for your help with this referral and please feel free to call me with any questions or concerns.

Sincerely,

I agree to the request for this assessment and give permission for my school district to exchange information with Dr. _____.

_____

Parent Signature and Date

_____

_____

Parent Name, Address and Phone Number (please print)

II. Request for Comprehensive Special Education Assessment with a focus on Other Health Impaired (OHI) category of disability

PRACTICE LETTERHEAD

Date:

Re: [patient name]
School Name and Grade (if applicable):
Date of Birth:

Dear Special Education Director,

[Patient name] is my patient. Today, s/he came in with his/her parent/guardian for an assessment of how his/her medical condition is impacting his/her educational performance. We request that [patient name] be given a comprehensive assessment in all areas of suspected disability. Please consider this a concurrent referral for assessment under Section 504 of the Rehabilitation Act. Some of the reasons are stated below.

In my judgment, I believe my patient qualifies for special education services under the Other Health Impairment (OHI) category of the Individuals with Disabilities Education Act (IDEA) because of his/her diagnosis of [patient diagnosis]. I understand that the OHI category of disability under IDEA means having limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that – (i) is due to chronic or acute health problems including but not limited to asthma, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia; and (ii) adversely affects a child's educational performance.

[Insert specific examples. For students with ADD/ADHD, link how the parents and/or educators see the child struggling in school and how you see the attentional issues playing into this process. If the child has a diagnosis of ADD/ADD, include this. For students with other medical issues, such as sickle cell, epilepsy, diabetes, allergies, bipolar disability, specify the connection you see between the condition and the child's inability to access/benefit from his/her education.]

I've let the parents know that after you receive this letter you will send the family an Assessment Plan in 15 calendar days for their review. I've let the family know to sign and return that form as soon as they agree or before 15 calendar days so that the assessment process can be completed and an IEP meeting held within the 60 day timeline from parent consent.

The parents request copies of the assessment reports as soon as available and at least 5 days before the IEP meeting to enable them to meaningfully participate in the IEP process. [Include email here if a family wants electronically.] Thank you for your help with this referral and please feel free to call me with any questions or concerns.

Sincerely,

I agree to the request for this assessment and give permission for my school district to exchange information with Dr. _____.

_____

Parent Signature and Date

_____

_____

Parent Name, Address and Phone Number (please print)

III. Request for School District Referral to County Mental Health for Assessment & Treatment (if eligible) under AB3632 Interagency Agreement

PRACTICE LETTERHEAD

Date:

Re: [patient name]
School Name and Grade (if applicable):
Date of Birth:

Dear Special Education Director,

[Patient name] is my patient. His/her parent/guardian reported to me today that s/he has recently had the following problems that are seriously and negatively impacting his/her ability to benefit from his/her public education:

[Insert specific examples such as: S/he is not attending to his/her education due to behavioral challenges such as (insert) and is unable to access instruction… Mental health concerns have not been alleviated by school intervention and they are increasing in occurrence and intensity… S/he is extremely anxious and has injured him/herself (or others.) S/he is growing increasingly withdrawn and depressed and now cannot even bring him/herself to attend school.]

I believe that this is due to as yet undiagnosed mental health issues.

Since the onset of these behaviors suggests possible underlying mental health disorder, I am asking you to make an AB3632 interagency referral to Alameda County Mental Health to assess his/her needs in this area of suspected disability. Whatever is going on with [patient name] is clearly affecting his/her educational performance. I understand these concerns warrant a mental health referral within the education system concurrent with initial comprehensive special education assessment in all areas of suspected disability, or for a student who has an Individualized Education Plan (IEP) who may also need mental health assessment.

Please proceed with my recommendation. I have spoken to [patient name]'s parents/guardian and they give their full consent to pursue further mental health assessment. Thank you for your time and willingness to follow up with this referral. You can reach me for further information at _____. Please send me a copy of the evaluation when completed.

Sincerely,

I agree to the request for this assessment and give permission for my school district to exchange information with Dr. _____.

_____

Parent Signature and Date

_____

_____

Parent Name, Address and Phone Number (please print)

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ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

WELLNESS PROGRAM REQUEST FORM

Alameda Alliance for Health provides free health education. We want you to take charge of your health by having the best information possible. Please check off the topics that you want.

WRITTEN MATERIALS:

- ❑ Advanced Directive (medical power of attorney)
- ❑ Alcohol and Other Substance Abuse
- ❑ Asthma ❑ Adult ❑ Child
- ❑ Back Care
- ❑ Birth Control and Family Planning
- ❑ Breastfeeding
- ❑ Diabetes
- ❑ Domestic Violence
- ❑ Exercise ❑ Resistance Bands
- ❑ Healthy Eating
- ❑ Heart Health
- ❑ Parenting and Discipline
- ❑ Pregnancy and Childbirth
- ❑ Quit Smoking
- ❑ Safety ❑ Baby ❑ Child ❑ Senior
- ❑ Sexual Health
- ❑ Stress and Depression

DVDS:

- ❑ Asthma Care ❑ Adult ❑ Child
- ❑ Exercise ❑ Child ❑ Family ❑ Senior
- ❑ Parenting and Disipline (Ages 0 - 3)

CLASSES & PROGRAMS:

- ❑ Asthma
- ❑ Alcohol and Other Substance Use
- ❑ Breastfeeding Support
- ❑ Diabetes
- ❑ CPR/First Aid
- ❑ Parenting
- ❑ Pregnancy and Childbirth
- ❑ Quit Smoking (have Smoker's Helpline call me)
- ❑ Healthy Weight
- ❑ Senior Centers/Programs

ID BRACELETS:

- ❑ Asthma
- ❑ Diabetes

SPECIAL BOOKS:

- ❑ Self-Care Guide ❑ Family ❑ Teen ❑ Senior
- ❑ What to Do When Your Child Gets Sick
- ❑ When Your Child is Heavy
- ❑ Cookbook
  (pick one) ❑ Soul ❑ Latin ❑ Healthy Meals
- ❑ Exercise
  (pick one) ❑ Yoga ❑ Strength ❑ Senior

Name (self): _____ Alliance ID Number: _____

Child's Name (if applicable): _____ Child's ID Number: _____

Address: _____

City: _____ Zip: _____

Daytime Phone #: _____ Language Preferred: _____

Provider Name (if applicable): _____ Email Address: _____

Materials are for: ❑ Adult ❑ Senior ❑ Child Age of Child: _____

Send this form to: Alameda Alliance for Health, 1240 South Loop Road, Alameda, CA 94502

Fax: 1-877-813-5151 ■ **Call:** (510) 747-4577 / CRS/TTY: 711 ■ **Email:** livehealthy@alamedaalliance.org

(HED W-1) Revised July 2014

ALAMEDA
Alliance
FOR HEALTH
Health care you can count on.
Service you can trust.

FORMULARIO DE SOLICITUD PARA EL PROGRAMA DE BIENESTAR

Alameda Alliance for Health provee educación de la salud gratuita. Queremos que usted se haga cargo de su salud con la mejor información posible. Marque los temas que le interesan.

MATERIALES ESCRITOS:

- ❑ instrucción anticipada (carta de poder médica)
- ❑ abuso de alcohol y de otras sustancias
- ❑ asma ❑ en adultos ❑ en niños
- ❑ cuidados de la espalda
- ❑ anticoncepción y planificación familiar
- ❑ lactancia
- ❑ diabetes
- ❑ violencia doméstica
- ❑ ejercicio ❑ bandas elásticas
- ❑ alimentación sana
- ❑ salud del corazón
- ❑ ser padre y la disciplina
- ❑ embarazo y parto
- ❑ dejar de fumar
- ❑ seguridad ❑ bebé ❑ niño ❑ adulto mayor
- ❑ salud sexual
- ❑ estrés y depresión

CLASES Y PROGRAMAS SOBRE:

- ❑ asma
- ❑ abuso de alcohol y de otras sustancias
- ❑ apoyo para el amamantamiento
- ❑ diabetes
- ❑ resucitación cardiopulmonar/primeros auxilios
- ❑ ser padre
- ❑ embarazo y parto
- ❑ dejar de fumar (haga que la línea de ayuda al fumador me llame)
- ❑ Healthy Weight (Peso saludable)
- ❑ Centro/Programas de adultos mayores

BRAZALETES DE IDENTIFICACIÓN:

- ❑ asma
- ❑ diabetes

DVD:

- ❑ atención del asma ❑ adultos ❑ niños
- ❑ ejercicio ❑ niños
- ❑ ser padre y la disciplina (edades de 0 a 3 años)

LIBROS ESPECIALES:

- ❑ Guía de autocuidado familiar ❑Familia ❑ Adolescente ❑ Adultos mayores
- ❑ What to Do When Your Child Gets Sick (Qué hacer cuando su hijo se enferma)
- ❑ When Your Child is Heavy (Cuando su hijo tiene sobrepeso)
- ❑ Recetario (elija uno) ❑Latino ❑ Comidas saludables
- ❑ Ejercicio (elija uno) ❑ Yoga ❑ Fuerza ❑Adulto mayor

Nombre (personal):_____ Número de identificación de Alliance:_____

Nombre del hijo (si es necesario):_____ Número de identificación del hijo:_____

Dirección:_____

Ciudad:_____ Código postal:_____

Número de teléfono durante el día:_____ Idioma de preferencia:_____

Nombre del proveedor (si es necesario):_____ Dirección de correo electrónico:_____

Los materiales son para: ❑ adultos ❑ personas de edad avanzada ❑ niños Edad del niño:_____

Envíe este formulario a: Alameda Alliance for Health, 1240 South Loop Road, Alameda, CA 94502

Fax: 1-877-813-5151 ■ **Llame al:** (510) 747-4577 o a las líneas CRS/TTY: 711

ALAMEDA
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Service you can trust.

安康保健計畫資料索取表格

Alameda Alliance for Health免費提供衛生知識教育。我們希望您充分瞭解情況，以便在保持健康方面掌握主動權。請勾選您希望索取的條目。

書面資料：

- ❑ 預設指示（醫療授權書）
- ❑ 酒精與其他毒品濫用
- ❑ 哮喘病 ❑ 成人 ❑ 兒童
- ❑ 背部護理
- ❑ 避孕與家庭生育計劃
- ❑ 母乳哺育
- ❑ 糖尿病
- ❑ 家庭暴力
- ❑ 健身鍛煉 ❑ 健身拉力帶
- ❑ 健康飲食
- ❑ 心臟健康
- ❑ 子女教養與管教
- ❑ 懷孕與分娩
- ❑ 戒煙
- ❑ 安全 ❑ 嬰兒 ❑ 兒童 ❑ 老年人
- ❑ 性衛生知識
- ❑ 壓力和抑鬱

講習班和計劃：

- ❑ 哮喘病
- ❑ 酒精與其他毒品濫用
- ❑ 母乳哺育支持服務
- ❑ 糖尿病
- ❑ 心肺復甦術培訓/急救
- ❑ 子女教養
- ❑ 懷孕與分娩
- ❑ 戒煙 （請讓吸煙者熱線打電話給我）
- ❑ 健康體重

識別腕帶：

- ❑ 哮喘病
- ❑ 糖尿病

特選書籍：

- ❑ What to Do When Your Child Gets Sick （《孩子生病時應如何辦》）
- ❑ 食譜

姓名（您本人）：_____ Alliance計畫成員識別號碼：_____

兒童姓名（若適用則請填寫）：_____ 兒童的識別號碼：_____

地址：_____

城市：_____ 郵遞區號：_____

日間電話號碼：_____ 首選語言：_____

服務提供者姓名或名稱（若適用則請填寫）：_____ 電郵地址：_____

為何人索取資料： ❑ 成人 ❑ 老年人 ❑ 兒童 兒童年齡：_____

請將此表格寄送至：Alameda Alliance for Health, 1240 South Loop Road, Alameda, CA 94502

傳真：1-877-813-5151 ■ **電話：**(510) 747-4577 / 加州電話轉接服務(CRS)/TTY專線： 711

ALAMEDA
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FOR HEALTH

Health care you can count on.
Service you can trust.

MẪU ĐƠN YÊU CẦU CỦA CHƯƠNG TRÌNH WELLNESS

Alameda Alliance for Health cung cấp dịch vụ giáo dục y tế miễn phí. Chúng tôi muốn quý vị kiểm soát được sức khỏe của mình bằng cách trang bị những thông tin tốt nhất có thể. Vui lòng đánh dấu những chủ đề quý vị muốn xem.

TÀI LIỆU VĂN BẢN:

- ❑ Chỉ Thị Trước (giấy ủy quyền về y tế)
- ❑ Chương Trình Lạm Dụng Rượu và Chất Kích Thích Khác
- ❑ Bệnh Suyễn ❑ Người Lớn ❑ Trẻ Em
- ❑ Chăm Sóc Lưng
- ❑ Ngừa Thai và Kế Hoạch Hoá Gia Đình
- ❑ Nuôi Con Bằng Sữa Mẹ
- ❑ Bệnh Tiểu Đường
- ❑ Bạo Hành Gia Đình
- ❑ Thể Dục ❑ Móc Dây Chịu Lực
- ❑ Ăn Uống Đúng Cách
- ❑ Sức Khoẻ Tim
- ❑ Làm Cha Mẹ và Kỷ Luật
- ❑ Mang Thai và Sinh Con
- ❑ Bỏ Thuốc Lá
- ❑ An Toàn ❑ Em bé ❑ Trẻ con ❑ Người Cao Niên
- ❑ Sức Khoẻ Tình Dục
- ❑ Căng Thẳng và Trầm Uất

CÁC LỚP HỌC VÀ CÁC CHƯƠNG TRÌNH

- ❑ Bệnh Suyễn
- ❑ Sử dụng Rượu và cá Dược chất khác
- ❑ Giúp nuôi con bằng sữa mẹ
- ❑ Bệnh Tiểu Đường
- ❑ CPR/Sơ Cứu
- ❑ Làm Cha Mẹ
- ❑ Mang Thai và Sinh Con
- ❑ Bỏ Thuốc Lá
  (cho đường Dây Bỏ Thuốc Lá gọi cho tôi)
- ❑ Trọng Lượng Lành Mạnh

VÒNG ĐEO TAY NHẬN DẠNG:

- ❑ Bệnh Suyễn
- ❑ Bệnh Tiểu Đường

SÁCH ĐẶC BIỆT:

- ❑ Cần Làm Gì Khi Trẻ Ốm
- ❑ Nhiều sách dạy nấu ăn

Tên (của quý vị):_____ Số ID Alliance:_____

Tên Trẻ (nếu có):_____ Số ID của Trẻ:_____

Địa chỉ:_____

Thành Phố:_____ Zip:_____

Số Điện Thoại Ban Ngày:_____ Ngôn Ngữ Lựa Chọn:_____

Tên Nhà Cung Cấp (nếu có):_____ Địa Chỉ Email:_____

Tài liệu dành cho: ❑ Người Lớn ❑ Người Cao Niên ❑ Trẻ Em Tuổi của Trẻ: _____

Gửi mẫu biểu này về: Alameda Alliance for Health, 1240 South Loop Road, Alameda, CA 94502

Fax đến: 1-877-813-5151 ■ **Gọi số:** (510) 747-4577 / CRS/TTY: 711 ■ **Email:** livehealthy@alamedaalliance.org