Care Support Plan

Name: _____ **Sex: M F** **Date of Birth:** ____/____/_____

Parents or guardian if not of age:
(Mom) _____ **(Dad)** _____

Address: _____

Phone: Home# (____)_____ **Cell# (_____) _____** **Work# (_____)_____**

PCP name: _____ **Phone: (_____) _____** **Fax # (_____) _____**

Insurance Company Name: _____

Referred By: _____**Phone: (_____) _____Date:** ____ /____/_____
Release signed? __Y __N -- for whom?
_____
_____

Principle reason for referral:

_____

Problem List:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Unique Case Facts: _____

_____

Allergies: _____

Date of past Support /Whom:

1._____ 5._____

2._____ 6. _____

3._____ 7._____

4. _____ 8._____

Consultants/Specialty /phone#/last visit date:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Home Care Nursing: Agency Name: _____

Contact: _____ phone: (_____)_____

Services Ordered: _____

Home Care Equipment: Company Name:_____ phone: (_____)_____

__ O2 stationary/portable
__Apnea monitor
__Trach tube type/size _____ / Cuff Yes/No
__Formula_____
__ N/G tube
__Carseat
__ BP monitor
__ O2 oximeter (SAT)
__ Suction machine/supplies
__Vent/type_____,
__Feeding pump/supplies
__GT/GJ (type_____ size___)
__Wheelchair
__ Other_____

Agencies working with: Company Name: _____ phone: (_____)_____

__PT:_____ __ OT: _____
__Speech:_____ __ Vision: _____

School: _____Gr._____ phone: (_____)_____
__IEP __504 __PLP __RTI Current? __ Y __ N Date_____

Disability Category:
__ASD __Deaf /Blind __Development Delay __Mental Illness __Emotional Disturbance __MR __OHI
__Multiple Disabilities __Orthopedic __S&L __ TBI __ Visual Impairment __Specific Learning Dis.

Evaluations: __District __Private Date_____ Type(s)_____

Do you have copies __ Y __ N

Community Resources:

__ BHDDH: Caseworker_____ phone: (_____)_____

__Technology Dependent __TBI __DDMR

__ Service: __Food Stamps __Child Care

__ CEDARR: Caseworker_____ phone: (_____)_____

__ SNAP

__ SSI: Caseworker _____ phone: (_____)_____

__ Housing Assistance

__ Medicaid: Caseworker_____ phone: (_____)_____

__ ORS: Case Worker _____ phone: (_____)_____

__ OTHER:_____ Case Worker _____ phone: (_____)_____

Mental Health: _____ phone: (_____)_____

Other:_____

Goals/ Family Meetings: **Last revision date: _____**

1._____ 4._____

2._____ 5._____

3._____ 6._____