**Youth’s Name:** Click or tap here to enter text. **CHC ID:** Click or tap here to enter text.

**Date Mailed:** Click or tap to enter a date. **Youth’s Date of Birth:** Click or tap to enter a date.

**Transition Readiness Changing Roles for Families**

**Complex Medical Needs Transition Checklist**

**This transition checklist is intended for youth with complex medical needs. Many youth with complex medical needs may need total assistance in self-care, decision making and expressing themselves.**

**Care Coordinators,** please assist the family if they have questions, need help, a referral, or follow-up. **Family Member,** please take time to answer the questions below about your youth**.** Place an X in the most appropriate box. If answering that family members or secondary caregivers need to learn, try to identify and list these family members or secondary caregivers. Work on a plan to increase their health care skills. Share the skills you are working on with the medical team. It takes time and practice to learn and demonstrate these skills so the best time to start is today!

|  |
| --- |
| **THE HEALTH OF MY YOUTH** |
|  | **I Know****(Yes)** | **I Need to Learn****(No)** | **Family/Other Caregivers Know** | **Family/Other Caregivers Need to Learn** | **Does Not Apply****(N/A)** |
| **I can explain the medical needs of my youth to others** |  |  |  |  |  |
| **I know when my youth needs to see a doctor quickly** |  |  |  |  |  |
| **I know what to do in case of a medical emergency with my youth** |  |  |  |  |  |
| **I know the exact dosages of all my youth’s medications** |  |  |  |  |  |
| **I have a written schedule of all my youth’s medications** |  |  |  |  |  |
| **I have a file with all my youth’s important information (Medical, etc….)** |  |  |  |  |  |
| **I have a copy of my youth’s current health care plan** |  |  |  |  |  |
| **I can explain my belief systems that might impact my youth’s medical care** |  |  |  |  |  |
| **I know that health care privacy changes at age 18** |  |  |  |  |  |

|  |
| --- |
| **USING HEALTH CARE** |
|  | **I Know****(Yes)** | **I Need to Learn****(No)** | **Family/****Other Caregivers** **Know** | **Family/Other Caregivers Need to Learn** | **Does Not Apply****(N/A)** |
| **Before my youth’s medical appointments, I write down any questions I have** |  |  |  |  |  |
| **I know how to get transportation for my youth’s scheduled medical appointments** |  |  |  |  |  |
| **I know how to contact my youth’s physician when the office is closed** |  |  |  |  |  |
| **I know where to get my youth’s labs ad x-rays** |  |  |  |  |  |
| **I know how to fill out medical forms for my youth** |  |  |  |  |  |
| **I understand how to use all my youth’s durable medical equipment** |  |  |  |  |  |
| **I know who to call if I have equipment problems** |  |  |  |  |  |
| **I understand my youth’s feeding regimen** |  |  |  |  |  |
| **I know how to get referrals for other providers for my youth** |  |  |  |  |  |
| **I have a plan to keep health insurance for my youth after the age of 18** |  |  |  |  |  |
| **I have received information regarding Advanced Directives**  |  |  |  |  |  |
| **I know about guardianship options after my youth turns 18** |  |  |  |  |  |
| **I have already begun the process to secure guardianship of my youth after age 18** |  |  |  |  |  |

**Family Quality Measurement**

**Care Coordinator,** this section is the opportunity for us to learn about the family’s experience with the Transition Readiness Checklist. If conducting the survey in-person or over the phone read each question and document the response from the Family Member. **Family Member**, please check ONE box for each question.

1) This checklist is helpful for planning my child's health care transition

* Strongly agree
* Agree
* Neither agree nor disagree
* Disagree
* Strongly disagree

2) You will be able to do everything that was discussed on the checklist

* Strongly agree
* Agree
* Neither agree nor disagree
* Disagree
* Strongly disagree

3) The health care transition is important to my child and family

* Strongly agree
* Agree
* Neither agree nor disagree
* Disagree
* Strongly disagree

**FOR Care Coordinator Use Only –** Please fill in the following information: The Care Coordinator’s name, the date the checklist was completed, the youth’s age and sex, the month they were identified, the method of administering the checklist and how the youth is classified by the Title V program. Once both sections are complete please enter into Survey Monkey Survey before placing this form in the youth’s chart.

|  |  |
| --- | --- |
| **Care Coordinator’s Name:** | **Child’s CHC ID:** |
| **Date Checklist Completed:** | **Youth Gender: Male [ ]  Female [ ]  Youth Age:** |
|  **Circle this Youth’s Birth Month****JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC** |
| **Classification: Check one box or both****[ ]  Youth has Intellectual Disability [ ]  Youth has Special Health Care Need** |
| **While completing the checklist, what was the highest level of interaction with the family? Check only one box****[ ]  In-Person [ ]  Over the phone [ ]  By mail [ ]  Mailed the tool, no response after 6 months** |