Care Coordination Plan

Demographic Information

Date: _____ Updated: _____ Primary Language: _____

Name: _____ Sex: _____ DOB: _____

Address: _____ County: _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Relationship: _____

Insurance Information

Name: _____ ID#:_____

Primary Insurance: _____ Phone#: _____

Secondary Insurance: _____ Phone#:_____

MA Case Manager: _____

SSI: Yes_____No_____

Hearing Loss Information

Type of HL	**Degree of HL**
Right: _____	**_____**
Left: _____	**_____**

Communication Modality:

ASL

Auditory Oral/Auditory Verbal

Cued Speech

Total Communication

Other Diagnoses:

1.

2.

3.

Medications

Medication	Dosage	Frequency		Medication	Dosage	Frequency

Care Coordination Plan

Technologies

Hearing Aids/Cochlear Implant Speech Processors

	Right	***Left***
Type of Device:		
Manufacturer:		
Model #:		
Serial Number:		
Date Fitted:		
Warranty Expiration:		
Equipment Supplier:		
Address:		
Phone:		

FM System

Manufacturer:	
Primary Channel:	
Receiver Model & Serial #:	
• **Right:**	
• **Left:**	
Transmitter Model & Serial #:	
Warranty Expiration:	
Equipment Supplier:	
Address:	
Phone:	

Other Durable Goods

Name:			**Name:**	
Address:			**Address:**	
Phone:			**Phone:**	
Equipment Supplied:			**Equipment Supplied:**	

Care Coordination Plan

Providers

Medical

Specialty	***Name***	***Phone Number***
PCP:		
Audiologists:		
ENT:		
Geneticist:		
Ophthalmologists:		
Other:		
Other:		
Other:		
Other:		

Family Resources

Specialty	***Name***	***Phone Number***	***Agency***
Type of Device:			
Manufacturer:			
Model #:			
Serial Number:			
Date Fitted:			
Warranty Expiration:			
Equipment Supplier:			
Address:			
Phone:			

Care Coordination Plan

Providers

Early Intervention

Specialty	***Name***	***Phone Number***	***Agency***
EI Coordinator			
EI Service Provider			
• **Teacher of Deaf/HH**			
• **OT**			
• **PT**			
• **Speech/Language**			
Other:			
Other:			
Other:			
Other:			
Other:			

Care Coordination Plan

Providers

Education:

Primary Education Contact:

Name:	
Phone:	

School:

Name:	
Address:	
Phone:	

Name:	
Address:	
Phone:	

Educational Advocate:

Name:	
Phone:	

Supplemental Services:

Name	***Phone Number***	***Type of Services***

Care Coordination Plan

Important Things To Do in the Next Month

Area of Need	***Date Discussed***	***Date Completed***
Early Intervention		
MA Application		
Obtaining Hearing Aids		
Medical Workup and Clearance: ENT		
Medical Workup and Clearance: Genetics		
Medical Workup and Clearance: Ophthalmology		
Information on Communication Options		
Family Connection		

Parent To Do List and Notes

Provider	***Date***	***Time***	***Notes***
EI Coordinator			
EI Service Provider			
• **Teacher of Deaf/HH**			
• **OT**			
• **PT**			
• **Speech/Language**			
Other:			
Other:			
Other:			
Other:			
Other:			