## Transition Screening Tool

Do you need assistance with or information about any of the following?

### Health
- Finding a primary care doctor to address my adult health care needs
- Finding a specialty care doctor
- Paying for adult health care
- Getting treatments, therapies, equipment, supplies or medication
- Connecting with agencies that can provide me with more information on my disability or special health care need (UCP, OI Foundation, MDA).

### Employment
- Career planning/job training
- Finding a job with supports and accommodations/job coach
- Services provided through Vocational Rehabilitation
- Keeping SSI while working and going to school

### Legal Rights
- Advocacy
- Selective Services Registration
- American with Disabilities Act
- Education rights/personal rights
- Guardianship Information
- Wills & Trust
- Advanced Directives

### Independent Living
- Accessible, affordable housing
- Supervised living programs
- Independent living supports
- Personal care attendant

### Psychosocial
- Family/support networks
- Support Groups
- Sexuality
- Depression/loneliness
- Stress management
- Anger/Violence at school or home
- Bullying
- Risk Taking Behavior (drugs, alcohol, smoking, unprotected sex)

### Education
- Accommodations at school/college for students with disabilities (IEP/504/ADA)
- Transition planning in high school
- Post secondary education
- Paying for school/college
- Vocational Rehabilitation

### Transportation
- Drivers education/license
- Adaptive driving equipment
- Public transportation

### Community Resources
- Social Security Benefits
- Health Insurance/Medicaid
- Division of Services for People with Disabilities (DSPD)
- Respite Care
- Mental Health Services
- Assistive Technology
- Recreation/Sports
- Assistance programs (food stamps, TANF, housing)
- Spiritual Home
- Leisure Activities

Do you have other questions or concerns about your future?

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Would you like to meet with a Care Coordinator today in clinic or be contacted by telephone?

- In clinic
- Telephone: _________________________ (phone number)
  _________________________ (contact person)
- No, thank you
TRANSITION ACTION CARE PLAN

YOUNG ADULT'S NAME ___________________________________ PARENTS/GUARDIAN _______________________________ DOB ___________ ID __________________

MALE    FEMALE    PRIMARY CARE PHYSICIAN _______________________________ REFERRED TO _______________________________

DIAGNOSIS ______________________________________________________________________________________________

OTHER AGENCIES INVOLVED __________________________________________________________________________________

SCHOOL _______________________________ SCHOOL CONTACT _______________________________

NEEDS  SSI  MEDICAID  HEALTH INSURANCE  GUARDIANSHIP _______________________________

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<tr>
<th>DATE</th>
<th>TRANSITION NEEDS IDENTIFIED</th>
<th>ACTION BY WHO WHEN</th>
<th>DATE COMPLETED</th>
<th>FUTURE SCHEDULING</th>
<th>STAFF/ PARENT INITIALS</th>
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DATES REVIEWED: _____________________________________________________________

From the Medical Home Portal www.medicalhomeportal.org, 2009