Health Department
Address:
Address:
Phone:
Fax:

CSHCS County Website:

Family Center for Children and Youth
with Special Heath Care Needs
Email Address CSHCSFC@ Michigan.gov
www.michigan.gov/cshcs
Family Phone Line: (800) 359-3722
Poison Control: (800) 222-1222

Section 1 – Case Information

1). Child/Beneficiary CSHCS/ Medicaid ID Number	2). Eligibility Period			3). Child/Beneficiary Name ☐Male ☐Female	
4). Date of Birth	5). Address			6). City	7). Zip
8). Mother/Guardian	9). Phone: Home: Work: Cell:			10). Father/Guardian	
11). Phone Home: Work: Cell	12). Family Email Address:			13). Foster Care/Other	
14). Alternate Caregiver/ Relationship	15). Phone	16). Work	17). Cell	18). Care Coordinator/ Case Manager	

19). Medical Summary:	
20). CSHCS Diagnosis(es) {codes with names added}	21). Other Diagnosis(es) {Non CSHCS elig. DX}
22). Other Health Concerns: ;	

23). Primary Health Care Provider		24). Phone	25). Fax:	26). Email:
27). Dentist:		28). Phone	29). Fax:	30). Email:
31). Preferred Pharmacy	32). Address	33). Phone	34). Fax:	35). Email:

36). Insurance
a. ☐ Primary b. ☐ Secondary c. ☐ MA /FFS d. ☐ MA/MHP
e. ☐ Pharmacy f. ☐ Vision g. ☐ Dental

37). Incontinent Supplier 38). Phone

39). Prov. Type	40). Name/ Location:	41). NPI#	42). Phone/Fax:	43). Last Visit	44). Next Visit
a. Click to Select	a.	a.	a.	a.	a.
b. Click to Select	Name/Location: b.	NPI# b.	Phone/Fax: b.	Last Visit b.	Next Visit b.
c. Click to Select	Name/Location c.	NPI# c.	Phone/Fax: c.	Last Visit c.	Next Visit c.
d. Click to Select	Name/Location d.	NPI# d.	Phone/Fax: d.	Last Visit d.	Next Visit d.
e. Click to Select	Name/Location e.	NPI# e.	Phone/Fax: e.	Last Visit e.	Next Visit e.
f. Click to Select	Name/Location f.	NPI# f.	Phone/Fax: f.	Last Visit f.	Next Visit f.
g. Click to Select	Name/Location g.	NPI# g.	Phone/Fax: g.	Last Visit g.	Next Visit g.
h. Click to Select	Name/Location h.	NPI# h.	Phone/Fax: h.	Last Visit h.	Next Visit h.
i. Click to Select	Name/Location i.	NPI# i.	Phone/Fax: i.	Last Visit i.	Next Visit i.
j. Click to Select	Name/Location j.	NPI# j.	Phone/Fax: j.	Last Visit j.	Next Visit j.
k. Click to Select	Name/Location k.	NPI# k.	Phone/Fax: k.	Last Visit k.	Next Visit k.

Name: Click here to enter text. ID # Click here to enter Click here to enter

45). Specialty Care Hospital	46). Phone	47). Fax:
48). Community Hospital:	49). Phone	50). Fax
51). CMS Clinic :	52). Phone	53). Fax
54). Lab:	55). Phone:	56). Fax:

Section 2 - Functional Status and Therapies

Key : (1) Infant (2) Independent (3) Needs Assistance (4) Dependent N/A=Not Applicable	
57) Mobility: AMB ( ) W/C ( ) Transfer ( ) Other ( )	58) ADLs: Dress ( ) Bath ( ) Toilet ( ) Feed ( )
59) Language/Communication/Sensory Issues: (vision, hearing, speech)	60) Height: Weight:

THERAPIES (School/Community/Private)		
61) Name/Facility	62)Type of Therapy	63) Treatment Plan
	Click to Select	
	Click to Select	
	Click to Select	

64) Comments:

Section 3 - Areas of Concern: If checked, comment below:

☐ Allergies ☐ Drug ☐ Other	☐ Immunizations not UTD per MCIR
☐ Cardiovascular	☐ Neurological/Seizures
☐ Dental	☐ Skin
☐ Endocrine/Metabolic	☐ Sleeping Patterns/ Safe Sleep
☐ Gastrointestinal	☐ Upcoming appointments, treatments
☐ Genitourinary	☐ Vision
☐ Hematological	☐ Other
☐ Hearing	☐

65) Comments:

Name: Click here to enter text. ID # Click here to enter Click here to enter

66) Medications:

Section 4 - Equipment & Supplies: Check if Using or Needed

☐ Apnea Monitor	☐ Gastrostomy Supplies	☐ Positioning Device
☐ Air Conditioning	☐ Glucometer	☐ Prosthetics
☐ Air Mattress	☐ Hearing Aid	☐ Pulse Oximeter
☐ Bath Chair	☐ Hospital Bed	☐ Scale
☐ BP Monitor	☐ House Ramp	☐ Shoe Lifts
☐ Car/Van Lift	☐ Incontinent Supplies	☐ Stander
☐ Car Seat/Booster	☐ IV Therapy	☐ Stroller
☐ Cochlear Implant Device	☐ Lifting Device	☐ Suction Machine
☐ Commode	☐ Nebulizer/Inhaler	☐ TPN Supplies
☐ Communication Device	☐ Orthodontia	☐ Trachestomy Supplies
☐ CPAP/BiPAP	☐ Orthotics	☐ Ventilator
☐ Diabetic Supplies	☐ Ostomy Supplies	☐ Walker
☐ Dialysis Supplies	☐ Oxygen	☐ Wheelchair
☐ Eyeglasses	☐ Peak Flow Meter	☐
☐ Feeding Chair	☐ Percussion Vest	☐

Section 5 – DME Medical Supplies

67) DME Provider/ Supplier / Phone	68) Item(s)		69) Due for Replacement

70) Comments:

Section 6 – Education/Psycho-Social

71) a. School Program: Grade level / Regular / Special Ed b. Contact: c. Phone:	72) Self-concept/ Family Strengths:
73) Transportation Method/ Status:	74) Family Support System
75) Current Educational Challenges /Satisfaction(IEP date; 504 plan)	76) Financial Impact

Name: Click here to enter text. ID # Click here to enter Click here to enter

77). Family Status/Summary

Section 7 – Goals/On-going Care Plan

78) Date	79) Problem/ Concern	80) Goal	81) Intervention/ Who will do	82) Outcome/ Barriers	83) Evaluation/Date Resolved
a.					
b.					
c.					
d.					

- Please review this Plan of Care (POC).
- If there are no changes or corrections, sign this page and return only this page in the enclosed envelope.
- Please call to make changes or corrections.

☐ Please send a copy to Primary Care Provider: Date Sent:

☐ Please send a copy to: Date Sent: ______________

Parent/Legal Guardian/Client Signature ________________________________ Date: ______________

Care Coordinator Signature ________________________________ Date: ______________

Public Heatlh Nurse's name: Phone:

Completed: ☐ in home ☐in office ☐ on phone

Name: Click here to enter text. ID # Click here to enter Click here to enter