

# Care Coordination Plan

## Demographic Information

Date: Updated: Primary Language:  
Name: Sex: DOB:  
Address: County:  
Parent/Guardian: Phone: Cell:  
Relationship:

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## Insurance Information

Name ID#  
Primary Insurance: Phone:  
Secondary Insurance: Phone:  
MA Case Manager:  
SSI: Y N

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## Hearing Loss Information

Type of HL Degree of HL  
R:  
L:  
Communication Modality:  
ASL Cued Speech  
Auditory Oral/Auditory Verbal Total Communication

### Other Diagnoses:

- 1.
- 2.
- 3.

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## 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 and Serial Number:    |  |
| • Right:                             |  |
| • Left:                              |  |
| Transmitter Model and Serial Number: |  |
| Warranty Expiration:                 |  |
| Equipment Supplier:                  |  |
| Address:                             |  |
| Phone:                               |  |

#### **Other Durable Goods**

|                     |  |
|---------------------|--|
| Name:               |  |
| Address:            |  |
| Phone:              |  |
| Equipment Supplied: |  |

|                     |  |
|---------------------|--|
| Name:               |  |
| Address:            |  |
| Phone:              |  |
| Equipment Supplied: |  |

For more information go to [www.paealyhearing.org](http://www.paealyhearing.org)

## Care Coordination Plan

### *Providers*

#### *Medical:*

| Specialty        | Name | Phone Number |
|------------------|------|--------------|
| PCP:             |      |              |
| Audiologist:     |      |              |
| ENT:             |      |              |
| Geneticist:      |      |              |
| Ophthalmologist: |      |              |
| Other:           |      |              |
| Other:           |      |              |
| Other:           |      |              |

#### *Family Resources:*

| Specialty             | Name | Phone Number | Agency |
|-----------------------|------|--------------|--------|
| Social Worker:        |      |              |        |
| Parent Advocate:      |      |              |        |
| Family Counselor:     |      |              |        |
| Peer Support Contact: |      |              |        |
| Other:                |      |              |        |
| Other:                |      |              |        |
| Other:                |      |              |        |

# 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: |  |

#### Supplementary Services:

| Name | Phone Number | Type of Services |
|------|--------------|------------------|
|      |              |                  |
|      |              |                  |
|      |              |                  |
|      |              |                  |



Care Coordination Plan

Parent To Do List and Notes (Cont.)

## Care Coordination Plan

### *Other Sections of Binder:*

#### Audiology

- Reports
- Test Results

#### Medical

- Reports
- Test Results

#### Education

- Reports
- Test Results

#### Resources