Youth Transition Plan Cover Sheet

Growing from a young person to adulthood is not always easy. When young people are challenged with special health care needs, more planning and services are needed.

The purpose of the following questionnaire is to help transitioning youth plan with their CMS social worker for meeting future needs.

Some of the questions may not be about you, and some are very personal. It is up to each family/youth to determine who will complete the questionnaire.

Healthy Transition New Mexico
Youth Transition Plan – "A"

This plan will help you prepare for your future. Some of these questions may not be about you. Please answer those that are about you. Thank you.

Youth's Name _____ Date _____ CMS# _____

Date of Birth: _____ Zip Code: _____

Health condition/Diagnosis: _____

Survey completed by: ☐ Youth ☐ Youth and parent/guardian

Health/Medical

1.

Knowledge & management of medical condition (Check appropriate box)	Always (Yes)	Some times	Never (No)	N/A
Can you describe your medical condition?				
Do you have a Primary Care Physician (PCP) that you see regularly?				
Does/has your medical provider discussed your medical condition with you?				
Do you prepare and ask questions of doctors, nurses, and therapists?				
Do you know when you will be too old to continue seeing your current medical provider?				
Do you manage your daily treatment needs?				
Has anyone talked with you about your medications?				
Do you understand what your medications do for/to you?				
Are you able to get the medications, supplies, equipment and/or therapies you need?				
Do you understand the laboratory and diagnostic tests you have had?				
Are your medical needs being met?				
Do you know your blood type, allergies, etc. and carry the information with you?				
Do you know when to replace durable medical equipment &/or supplies?				
Do you use street drugs or drink alcohol such as beer, wine or other liquor?				
Do you have a Specialty doctor that you see regularly?				
Do you wear a Medic-Alert bracelet/necklace?				
Has anyone talked with you about how your health condition is going to affect your sexual development and having children?				
Has someone talked to you about diseases you can catch from having sex?				
Do you understand how to keep from getting pregnant?				
GIRLS ONLY: Do you check your breasts for lumps monthly?				
BOYS ONLY: Do you check your testicles for lumps monthly?				

Daily Living

2. Here is a list of some activities. Please check what you do on a regular basis.

Activity	Check here
Spend time with family	
Spend time with friends	
Go grocery shopping	
Go to church	
Go to sports events, movies, concerts	
Play sports or work with sports team	
Play musical instruments/do artistic things	
Hobbies (read, sewing, model building)	
Use tobacco (smoke/chew)	
Exercise	
Use drugs/alcohol	
Drive a car	
Do household chores (laundry, cooking, cleaning)	
Manage your own money	
Use the library	
Other (please describe):	

3.

Do you do the following activities alone, with help or total assistance:	Alone	With help	Total assistance
Walk or move around use wheelchair ☐			
Move (like from a chair to a bench)			
Communicate			
Write			
Groom (bathe, dress, . . .)			
Care for your daily health needs			
Use special equipment do not use any ☐			
Take medication do not take any ☐			
Know when you are healthy or getting sick			
Know how to access services in your community			
Use public transportation (bus) not available in area ☐			
Other: (please tell us)			

Healthy Transition New Mexico

Youth Transition Plan – "A"

Education/Training/Employment Please check yes or no and fill in the blanks if needed.

4. Who has talked to you about your future, such as: getting a job, job training, college, etc.? Please check all that apply.

	Job Training/ college, vocational, trade school	Getting a job	Getting age-appropriate medical care	Living on your own
Family Member(s)				
School				
Medical Care Providers				
DVR (Department of Vocational Rehabilitation)				
CMS (Children's Medical Services)				
Friends/People in the community (clubs, neighbors)				
Helping Organization (Please name)				

Other
(Please name)

5. Do you participate in your Individual Education Plan (IEP) and/or 504 Plan? ☐ Yes ☐ No

6. Are you in school and/or a training program? ☐ Yes ☐ No

Do you receive the recommended services? ☐ Yes ☐ No

7. What was the last grade, college year or training you completed?

☐ High School ☐ Grade ☐ College Year

☐ Other (please tell us)

8. Do you have plans to get more schooling and/or training in the next few years?

☐ Yes, please tell us: ☐ No ☐ Don't Know

9. Are you currently working (including volunteer work)? ☐ Yes ☐ No

☐ Full-Time ☐ Part-Time

10. Do you need any special help to assist you at work? ☐ Yes ☐ No

If yes, what?

11. Do you have health insurance coverage? ☐ Yes ☐ No

Through your job? ☐ Yes ☐ No

Through your parents? ☐ Yes ☐ No

Through Medicaid? ☐ Yes ☐ No

Other? ☐ Yes ☐ No

If yes, do they limit coverage for pre-existing conditions? ☐ Yes ☐ No

12. Are you currently receiving Supplemental Security Income (SSI) benefits or any other type of public assistance (DD Waiver, D&E Waiver, Medically Fragile Waiver)? ☐ Yes ☐ No

If yes, what type?

Healthy Transition New Mexico
Youth Transition Plan – "A"

Living Arrangements

13. Where do you hope to live as an adult?
☐ a. Rent house/apartment ☐ b. With parent/relative ☐ c. With spouse
☐ d. Own house/apartment ☐ e. With friends ☐ f. House/apartment with support
☐ g. Other (please tell us) _____

14. What type of help would you need to live where you want?
☐ a. None ☐ b. Financial ☐ c. Assistance/personal aid
☐ d. Transportation ☐ e. Spouse/friend ☐ f. Home equipment
☐ g. Other (please tell us) _____

Transportation

15. What kinds of transportation do you use/plan to use to get around the community?
☐ a. Own car ☐ b. Family car ☐ c. Friends/family
☐ d. City bus ☐ e. Walking ☐ f. Taxi
☐ g. Car pools ☐ h. Other (please tell us) _____
_____

Recreation/Social Relationships

16. What kind of help would you need to participate in social activities?
☐ a. Friend/companion ☐ b. Special equipment/devices ☐ c. Transportation
☐ d. Other (please tell us):_____

17. Are you a member of a group like the Boys/Girls Club, a support group like Young Adults with Diabetes, or a church group? ☐ Yes ☐ No
Please tell us:

18. Would you like information about groups you could get involved with? ☐ Yes ☐ No

19.

Emergency (Check appropriate box)	Always (Yes)	Some times	Never (No)	N/A
Do you know who to call if you have a medical emergency?				
Do you carry these medical numbers with you?				
Do you have a phone to use in case of an emergency?				
Do you have the phone numbers of family and friends to call in case of an emergency?				
Do you know where the closest hospital is?				
Have you applied for any special program offered by your utility company (electric, gas, phone)?				

20.

Record Keeping (Check appropriate box)	Always (Yes)	Some times	Never (No)	N/A
Do you get a copy of your health records & medical information?				
Do you schedule your own medical/dental appointments?				
Do you carry your insurance card and/or a copy of it?				

21.

Dental & Vision (Check appropriate box)	Always (Yes)	Some times	Never (No)
Do you have a check-up with a dentist at least once a year?			
Do you brush and floss your teeth daily?			
Do you have a vision exam at least every two years?			

Final Question

Which would be the most helpful for your future?

- ☐ Job Training
- ☐ College education
- ☐ Having health insurance
- ☐ Vehicle modifications
- ☐ Assisted Living
- ☐ Guardianship
- ☐ Community recreation
- ☐ Housing
- ☐ Getting a job
- ☐ Driver's license
- ☐ Income support
- ☐ Other (please list) _____
- ☐ Counseling
- ☐ Support groups
- ☐ Manage money
- ☐ Transportation
- ☐ Medical services

Your CMS Social worker will talk to you about this survey

If this survey has raised any questions or concerns, please contact your CMS Social Worker

_____ at _____.

Healthy Transition New Mexico
Youth Transition Plan – "B"

This plan will help you prepare for your future. Some of these questions may not be about you. Please answer those that are about you. Thank you.

Youth's Name _____ Date _____ CMS# _____

Date of Birth: _____ Zip Code: _____

Health condition/Diagnosis: _____

Survey completed by: ☐ Youth ☐ Youth and parent/guardian

Health/Medical

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Do you know when you will be too old to continue seeing your current medical provider?				
Do you manage your daily treatment needs?				
Has anyone talked with you about your medications?				
Do you understand what your medications do for/to you?				
Are you able to get the medications, supplies, equipment and/or therapies you need?				
Do you understand the laboratory and diagnostic tests you have had?				
Are your medical needs being met?				
Do you know your blood type, allergies, etc. and carry the information with you?				
Do you know when to replace durable medical equipment &/or supplies?				
Do you use street drugs or drink alcohol such as beer, wine or other liquor?				
Do you have a Specialty doctor that you see regularly?				
Do you wear a Medic-Alert bracelet/necklace?				
Has anyone talked with you about how your health condition is going to affect your sexual development and having children?				
Has someone talked to you about diseases you can catch from having sex?				
Do you understand how to keep from getting pregnant?				
GIRLS ONLY: Do you check your breasts for lumps monthly?				
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Daily Living

2. Here is a list of some activities. Please check what you do on a regular basis.

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Play sports or work with sports team	
Play musical instruments/do artistic things	
Hobbies (read, sewing, model building)	
Use tobacco (smoke/chew)	
Exercise	
Use drugs/alcohol	
Drive a car	
Do household chores (laundry, cooking, cleaning)	
Manage your own money	
Use the library	
Other (please describe):	

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Do you do the following activities alone, with help or total assistance:	Alone	With help	Total assistance
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Move (like from a chair to a bench)			
Communicate			
Write			
Groom (bathe, dress, . . .)			
Care for your daily health needs			
Use special equipment do not use any ☐			
Take medication do not take any ☐			
Know when you are healthy or getting sick			
Know how to access services in your community			
Use public transportation (bus) not available in area ☐			
Other: (please tell us)			

Healthy Transition New Mexico

Youth Transition Plan – "B"

Education/Training/Employment

Please check yes or no and fill in the blanks if needed.

4. Who has talked to you about your future, such as: getting a job, job training, college, etc.? Please check all that apply.

	Job Training/ college, vocational, trade school	Getting a job	Getting age-appropriate medical care	Living on your own
Family Member(s)				
School				
Medical Care Providers				
DVR (Department of Vocational Rehabilitation)				
CMS (Children's Medical Services)				
Friends/People in the community (clubs, neighbors)				
Helping Organization, such as Catholic Charities (Please name)				
Other (Please name)				

5. Do you participate in your Individual Education Plan (IEP) and/or 504 Plan? ☐ Yes ☐ No

6. Are you in school and/or a training program? ☐ Yes ☐ No

   Do you receive the recommended services? ☐ Yes ☐ No

7. What was the last grade, college year or training you completed?

   ☐ High School ☐ Grade ☐ College Year

   ☐ Other (please tell us)

8. Do you have plans to get more schooling and/or training in the next few years?

   ☐ Yes, please tell us: ☐ No ☐ Don't Know

9. Are you currently working (including volunteer work)? ☐ Yes ☐ No

   ☐ Full-Time ☐ Part-Time

10. Do you need any special help to assist you at work? ☐ Yes ☐ No

    If yes, what?

Living Arrangements

11. Where do you hope to live as an adult?

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    ☐ g. Other (please tell us) _____

12. What type of help would you need to live where you want?

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Transportation

13. What kinds of transportation do you use/plan to use to get around the community?
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Recreation/Social Relationships

14. What kind of help would you need to participate in social activities?
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Please tell us:

16. Would you like information about groups you could get involved with? ☐ Yes ☐ No

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Do you know where the closest hospital is?				
Have you applied for any special program offered by your utility company (electric, gas, phone)?				

20.

Record Keeping (Check appropriate box)	Always (Yes)	Some times	Never (No)	N/A
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Dental & Vision (Check appropriate box)	Always (Yes)	Some times	Never (No)
Do you have a check-up with a dentist at least once a year?			
Do you brush and floss your teeth daily?			
Do you have a vision exam at least every two years?			

Final Question

Which would be the most helpful for your future?

☐ Job Training	☐ Community recreation	☐ Counseling
☐ College education	☐ Housing	☐ Support groups
☐ Having health insurance	☐ Getting a job	☐ Manage money
☐ Vehicle modifications	☐ Knowing your rights	☐ Transportation
☐ Assisted Living	☐ Medical services	

☐ Other (please list)_____

Your CMS Social worker will talk to you about this survey

If this survey has raised any questions or concerns, please contact your CMS Social Worker

_____ at _____.