

INTERAGENCY AGREEMENT

BETWEEN

SANTA BARBARA COUNTY

SPECIAL EDUCATION LOCAL PLAN AREA

AND

SANTA BARBARA

CALIFORNIA CHILDREN'S SERVICES

Final Version - December 1, 2011

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INTRODUCTION

The purpose of this agreement is to establish working procedures to encourage interagency cooperation in the provision of services to children with disabilities.

It is the intent of this agreement to:

1. Determine each agency's responsibility to the individual, including which services are to be provided by each agency;
2. Delineate which agency assumes the fiscal responsibility for providing the service to the individual;
3. Ensure that all children with disabilities have a free and appropriate public education as required by federal and state laws, regardless of the public agency administering the program;
4. Provide an uninterrupted flow of education to the individual as indicated in each individualized education plan and therapy services as indicated in the CCS medical therapy plan;
5. Establish procedures for reviewing and updating the interagency agreement as necessary;
6. Establish joint planning at the local level to ensure that resources will be utilized in the most efficient manner;
7. Assure non-duplication of service;
8. Establish and maintain channels of communications between the education agencies and CCS.
9. Reflect the guidelines included in the State Interagency Agreement between California Department of Education (CDE), Special Education Division and Department of Health Services, Children's Medical Services Branch (CMS), California Children's Services (CCS) Medical Therapy Program (MTP).

A. INDIVIDUAL'S SERVICE NEED: Standards	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
<p>Santa Barbara County Special Education Local Plan Area will:</p> <ol style="list-style-type: none"> 1. Provide the appropriate educational program and environment for individuals with exceptional needs according to their IEP and federal and state laws. 2. Use all services available through CCS before expending any funds to provide such services to individuals with exceptional needs. 	<p>Santa Barbara County California Children Services Program will:</p> <ol style="list-style-type: none"> 1. Provide physical and occupational therapy services under medical supervision to individuals in accordance with standards established by the CCS Program. 2. Assure that the services provided by physicians, physical therapists, and occupational therapists in the CCS Medical Therapy Program are in accordance with state licensure and professional ethics. 3. Provide diagnostic and medical treatment services to individuals in accordance with standards established by the CCS program. 4. Provide and maintain durable medical equipment as prescribed by a CCS panel physician for the sole use of the CCS client e.g. wheelchairs, crutches, per CCS treatment program eligibility standards.

B. INDIVIDUAL'S SERVICE NEED: Referrals

EDUCATION	CALIFORNIA CHILDREN'S SERVICES
<p>Santa Barbara County Special Education Local Plan Area will:</p>	<p>Santa Barbara County California Children's Services Program will:</p>
<ol style="list-style-type: none"> 1. Refer any individual birth to 21 years of age who has or is suspected of having a neuromuscular, musculoskeletal, or other physical disability requiring medically necessary occupational or physical therapy to the local California Children's Services Program (see Appendix A and B for CCS eligible conditions) utilizing the procedure outlined below: <ul style="list-style-type: none"> • Complete referral packet (Appendix C) including all items on the "Checklist for LEA Referrals for CCS Medical Therapy Program Services." • Include all the information requested on the forms. • Send to CCS administrative office, 345 Camino del Remedio, Santa Barbara, CA 93101. 2. Refer the parent to the CCS Therapy Services Coordinator when a student has been receiving CCS Therapy in another county and moves into the Santa Barbara SELPA. 3. Using the procedure outlined in item #1, refer the parent of students from out-of-state who have been receiving OT/PT per their IEP and are suspected of having a CCS eligible condition to CCS for review of their records to determine medical eligibility and need based on CCS eligibility criteria. Students not suspected of having a CCS eligible condition will be referred to SELPA. 	<ol style="list-style-type: none"> 1. Review all referrals which appear to meet CCS criteria or which are questionable and determine medical eligibility for services (see Appendix A & B). 2. Provide diagnostic, treatment, and medical therapy services in accordance with standards established by the California Children's Services Program. 3. Refer any individual suspected of needing educational support services to the director/coordinator of the local education agency as listed in Appendix F.

B. INDIVIDUAL'S SERVICE NEED: Referrals (CONTINUED)

<p>EDUCATION</p>	<p>CALIFORNIA CHILDREN'S SERVICES</p>
<p>Santa Barbara County Special Education Local Plan Area will:</p>	<p>Santa Barbara County California Children's Services Program will:</p>
<p>4. Refer any individual, birth to 21 years of age, who has or is suspected of having a medical condition which is eligible for CCS diagnostic or treatment services (see Appendix B) by completing the CCS Request for Service packet (Appendix C) and forwarding the form to the CCS office at the address listed on the form, attaching any relevant medical records.</p>	

C. INDIVIDUAL'S SERVICE NEED: Assessment	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
<p>Santa Barbara County Special Education Local Plan Area will:</p> <ol style="list-style-type: none"> 1. Assess the individual according to assessment requirements of federal and state laws. 2. With parental consent, will forward a copy of the assessment report to the CCS MTU. 	<p>Santa Barbara County California Children's Services Program will:</p> <ol style="list-style-type: none"> 1. Assess all medically eligible individuals in accordance with State CCS standards and federal and state law. 2. With parental consent will send a copy of the CCS physical and/or occupational therapy evaluation to the LEA.

D. INDIVIDUAL'S SERVICE NEED: CCS Medical-Therapy Conference

<p>EDUCATION</p>	<p>Santa Barbara County Special Education Local Plan Area will:</p>
<p>CALIFORNIA CHILDREN'S SERVICES</p>	<p>Santa Barbara County California Children's Services Program will:</p>
<p>1. Release personnel, when appropriate, for attendance at a pupil's scheduled CCS Medical-Therapy Conference Appointment.</p>	<p>1. Use a CCS Medical-Therapy Conference Team as needed to evaluate and determine the rehabilitation needs of medically eligible individuals including bracing, surgery, physical therapy, occupational therapy, and equipment.</p>

E. INDIVIDUAL'S SERVICE NEED: IEP Development, Implementation, and Review	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
<p>Santa Barbara County Special Education Local Plan Area will:</p> <ol style="list-style-type: none"> 1. Provide prior notice to the appropriate CCS Medical Therapy Unit for all IEP meetings of individuals receiving CCS occupational and/or physical therapy services. 2. Ensure that the child's IEP reflects the current level of CCS therapy services provided by attaching a copy of the current approved CCS Medical Therapy Plan/Prescription to IEP when provided. (Appendix D-5). 3. Identify specialized equipment in the IEP when needed for achieving educational objectives. 4. Include transportation to and from therapy in the IEP when needed. 5. With parental consent send a copy of the IEP to the designated MTU when CCS therapy services and/or transportation to/from the therapy site are included on the IEP. 6. If CCS notifies LEA/SELPA administrator or designee that CCS is unable to provide services in the approved CCS Medical Therapy Plan/IEP, the SELPA administrator shall engage in the following process: <ol style="list-style-type: none"> a. Interagency team meets to discuss recruitment plan. b. Reimbursement at current contract rate or a negotiated rate between SBCSEPA and CCS plus an administrative fee of 15% shall be paid by CCS to the LEA. 	<p>Santa Barbara County California Children's Services Program will:</p> <ol style="list-style-type: none"> 1. Participate, with parental consent, in the development of the IEP in accordance with State CCS standards and state and federal laws. Such participation may include attendance by a CCS staff member at the IEP meeting, provision of written information concerning the need for CCS occupational and/or physical therapy, or conference calls, together with written recommendations. 2. Provide, with parental consent, a copy of the current approved CCS Medical Therapy Plan Prescription, within 15 days of MD signature to the LEA Administrator or designee for the purpose of updating the IEP. (Appendix D-5) 3. Provide at least 10 days prior notice to the LEA Administrator or designee noted as the contact person on the IEP Notification of Meeting form and the parent of a possible change in the CCS medical therapy program services which may necessitate a change in the IEP. This notice will be in the form of a copy of the Medical Therapy Conference Notice. (See Appendix D-4)

E. INDIVIDUAL'S SERVICE NEED: IEP Development, Implementation, and Review (CONTINUED)	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
<p>Santa Barbara County Special Education Local Plan Area will:</p>	<p>Santa Barbara County California Children's Services Program will:</p>
	<ol style="list-style-type: none"> 4. Upon request from LEA, provide recommendations for durable medical equipment needed for the implementation of the student's IEP. 5. Inform the student's district transportation provider when transportation to and/or from therapy is needed. 6. CCS will inform the LEA administrator or designee if the student with an IEP is discharged from MTU services. 7. CCS will notify the LEA/SELPA administrator or designee if CCS is unable to provide services as stated in approved CCS Medical Therapy Plan and contained in the IEP

<p align="center">F. INDIVIDUAL'S SERVICE NEED: Least Restrictive Environment</p>	
<p align="center">EDUCATION</p>	<p align="center">CALIFORNIA CHILDREN'S SERVICES</p>
<p>Santa Barbara County Special Education Local Plan Area will:</p> <ol style="list-style-type: none"> 1. Ensure that, to the maximum extent appropriate, children with disabilities, including children in public or private institutions, are educated with children who are not disabled. 	<p>Santa Barbara County California Children's Services Program will:</p> <ol style="list-style-type: none"> 1. Assist the LEA in evaluating those aspects of the pupil's physical disability relating to placement in the least restrictive environment, e.g., architectural considerations and special equipment needs.

<p align="center">G. INDIVIDUAL'S SERVICE NEED: Medical Therapy Unit Facilities and Equipment</p>	
<p align="center">EDUCATION</p>	<p align="center">CALIFORNIA CHILDREN'S SERVICES</p>
<p>Santa Barbara County Special Education Local Plan Area will:</p>	<p>Santa Barbara County California Children's Services Program will:</p>
<ol style="list-style-type: none"> 1. Provide and maintain the necessary facilities, equipment and supplies as specified in Statewide Facilities Standards for CCS MTUs on a twelve month a year basis. 2. Repair and replace equipment, facilities and supplies as necessary. 3. Establish an annual budget for supplies, equipment and facilities used by the Medical Therapy Units. 4. On an annual basis, jointly review with the CCS Therapy Services Coordinator the projected equipment and facility needs for Medical Therapy Units in the SELPA. 5. Identify through revisions to the SELPA Local Plan any changes in fiscal/administrative responsibility for the provision and maintenance of necessary MTU space, equipment and supplies. 	<ol style="list-style-type: none"> 1. Coordinate with the Director of the Santa Barbara County SELPA the provision and maintenance of MTU facilities as specified in the SELPA Local Plan and in the Statewide Facilities Standards for CCS MTUs. 2. On an annual basis, jointly review with the SELPA Director the projected equipment and facility needs for Medical Therapy Unit services in the SELPA.

<p align="center">H. INDIVIDUAL'S SERVICE NEED: MTU Satellite Facilities and Equipment</p>	
<p align="center">EDUCATION</p>	<p align="center">CALIFORNIA CHILDREN'S SERVICES</p>
<p>Santa Barbara County Special Education Local Plan Area will:</p>	<p>Santa Barbara County California Children's Services Program will:</p>
<ol style="list-style-type: none"> 1. Coordinate with local school districts the provision and maintenance of MTU satellite facilities as specified in the SELPA Local Plan and Statewide Facility Standards for MTUs. 2. On an annual basis jointly review with the CCS Therapy Services Coordinator the projected equipment and facility needs for satellite services in the SELPA. 3. Identify through revisions to the SELPA Local Plan any changes in fiscal/administrative responsibility for the provision and maintenance of necessary satellite space, equipment and supplies. 4. Jointly establish a plan for the use of classrooms or MTU Satellite space when educational or therapy services are not being provided 5 days per week. 	<ol style="list-style-type: none"> 1. Coordinate with the Director of the Santa Barbara County SELPA the provision and maintenance of MTU satellite facilities as specified in the SELPA Local Plan and Statewide Standards for MTUs. 2. On an annual basis, jointly review with the SELPA Director the projected equipment and facility needs for satellite services in the SELPA taking into consideration the number of hours of prescribed services and space required to provide those services. 3. Jointly establish a plan for the use of classrooms or MTU Satellite space when educational or therapy services are not being provided 5 days per week taking into consideration the number of hours of prescribed services and space required to provide those services.

<p align="center">I. INDIVIDUAL'S SERVICE NEED: Location of MTU and Satellite Sites</p>	
<p align="center">EDUCATION</p>	<p align="center">CALIFORNIA CHILDREN SERVICES</p>
<p>Santa Barbara County Special Education Local Plan Area will:</p>	<p>Santa Barbara County California Children Services Program will:</p>
<ol style="list-style-type: none"> 1. Annually, with the local CCS, re-evaluate the appropriateness of MTU and satellite locations and adequacy of space needed per current state guidelines. 2. Jointly plan with the local and state CCS for MTU and satellite establishment and relocation per current state guidelines. 3. In the event the relocation of an MTU or MTU Satellite shall become necessary, the LEA will notify CCS by July 1 of the prior school year. 4. CCS shall be notified by January 15 of the prior school year of the proposed new MTU or MTU Satellite location; the proposed new MTU or MTU Satellite location shall be mutually agreed upon by county. 	<ol style="list-style-type: none"> 1. Annually, with the SELPA, re-evaluate the appropriateness of MTU and satellite locations and adequacy of space needed per current state guidelines. 2. Jointly plan with the SELPA for MTU and satellite establishment and relocation per current state guidelines.

<p align="center">J. INDIVIDUAL'S SERVICE NEED: Resolution of Disagreements and Due Process</p>	
<p align="center">EDUCATION</p>	<p align="center">CALIFORNIA CHILDREN'S SERVICES</p>
<p>Santa Barbara County Special Education Local Plan Area will:</p>	<p>Santa Barbara County California Children's Services Program will:</p>
<ol style="list-style-type: none"> 1. Inform parents of their rights to due process. 2. Refer parents with concerns about their child's CCS Therapy Program to the CCS Therapy Staff. 3. Encourage parents to participate in an IEP meeting for resolution of disagreements relating to their child's educational placement or program. 	<ol style="list-style-type: none"> 1. Inform parents of their rights to a second medical opinion appeal using the CCS Medical Therapy Program Dispute Resolution Process - 2nd Expert Opinion. (see Appendix E) 2. Refer parents with concerns about their child's educational placement or program to the LEA Staff. 3. Encourage parents to participate in the CCS MTU Conference/Clinic for resolution of therapy related disagreements.

<p style="text-align: center;">K. INDIVIDUAL'S SERVICE NEED: Confidentiality and Exchange of Information</p>	
<p style="text-align: center;">EDUCATION</p>	<p style="text-align: center;">CALIFORNIA CHILDREN'S SERVICES</p>
<p>Santa Barbara County Special Education Local Plan Area will:</p>	<p>Santa Barbara County California Children's Services Program will:</p>
<ol style="list-style-type: none"> 1. Acknowledge the protections afforded to student health information under regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), students' records under the Family Educational Rights and Privacy Act of the Education Code, and under provisions of state law relating to privacy. The Parties will ensure that all activities undertaken under this MOU will conform to the requirements of these laws. 2. Provide to CCS in a timely manner relevant information concerning the pupil with a disability upon receipt of the parent's informed consent. 	<ol style="list-style-type: none"> 1. Acknowledge the protections afforded to student health information under regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), students' records under the Family Educational Rights and Privacy Act of the Education Code, and under provisions of state law relating to privacy. The Parties will ensure that all activities undertaken under this MOU will conform to the requirements of these laws. 2. Provide to the Local Education Agency in a timely manner relevant information concerning the pupil with a disability upon receipt of the parent's informed consent.

L. STAFF DEVELOPMENT

<p>EDUCATION</p>	<p>CALIFORNIA CHILDREN'S SERVICES</p>
<p>Santa Barbara County Special Education Local Plan Area will:</p>	<p>Santa Barbara County California Children's Services Program will:</p>
<ol style="list-style-type: none"> 1. Cooperate and collaborate in the provision of appropriate staff development activities to ensure implementation of the Interagency Agreement. 2. Share information with CCS staff regarding relevant SELPA staff development activities. 	<ol style="list-style-type: none"> 1. Cooperate and collaborate in the provision of appropriate staff development activities to ensure implementation of the Interagency Agreement. 2. Share information with SELPA staff regarding relevant CCS staff development activities. 3. MTU staff will participate in all site emergency preparedness training and inservices, including fire and earthquake drills

M. ADMINISTRATION	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
<p>Santa Barbara County Special Education Local Plan Area will:</p> <ol style="list-style-type: none"> 1. The Director of the Santa Barbara County SELPA shall serve as the liaison for the Santa Barbara County SELPA to California Children's Services. 2. The contact person for each LEA within the SELPA is listed in Appendix F of this agreement. 3. It is the policy of the Department of Education that the LEA accept the CCS assessment determinations for medically necessary physical therapy and occupational therapy. 4. It is understood that the SELPA and its participating LEAs shall not presume or determine CCS eligibility nor make CCS service recommendations. 	<p>Santa Barbara County California Children's Services Program will:</p> <ol style="list-style-type: none"> 1. The CCS Coordinator of Therapy and Clinic Services shall serve as the liaison for California Children's Services to the Santa Barbara County SELPA. 2. The contact person for each Santa Barbara County California Children's Services MTU is listed in Appendix F of this agreement. 3. It is the policy of the Department of Health that the local CCS accept the LEA assessment determination for educational placement and services. 4. It is understood that CCS shall not presume or determine eligibility for special education nor make educational programs or service recommendations. 5. In the event that a parent makes a request from CCS for a recommendation for specialized equipment to be used in a school based program, CCS will refer the parent to their special education case manager to request a consultation with CCS.

N. DISPUTE RESOLUTION	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
<p>Santa Barbara County Special Education Local Plan Area will:</p> <ol style="list-style-type: none"> 1. Agree to work cooperatively with CCS to minimize interagency disputes and if such disputes occur will seek a speedy resolution. 2. Make every attempt to resolve the dispute at the lowest possible administrative level. 3. Seek resolution of disputes through involvement of the SELPA Director prior to requesting intervention by the Superintendent of Public Instruction. 4. Ensure that the dispute procedures shall not interfere with the right of a pupil with a disability to receive a free appropriate public education. 	<p>Santa Barbara County California Children's Services Program will:</p> <ol style="list-style-type: none"> 1. Agree to work cooperatively with SELPA and the SELPA LEAs to minimize interagency disputes and if such disputes occur will seek a speedy resolution. 2. Make every attempt to resolve the dispute at the lowest possible administrative level. 3. Seek resolution of disputes through involvement of the CCS Coordinator of Therapy Services prior to requesting intervention by the Southern California Regional Office of CCS. 4. Ensure that the dispute procedures shall not interfere with the right of a pupil with a disability to receive a free appropriate public education.

DIRECTORY OF AGENCY CONTACTS

CALIFORNIA CHILDREN SERVICES	HEATHER BOUVIER Clinical Education Coordinator 345 Camino del Remedio Santa Barbara, CA 93101	681-5362
CARPINTERIA	RUTH RECH Director, Pupil Services Carpinteria Unified School District 1400 North Linden Avenue Carpinteria, CA 93013	684-7657
FAMILY PARTNERSHIP CHARTER SCHOOL	TODD MITCHELL Executive Director PO Box 490 Santa Maria, CA 93454	348-3333 904-0087
GOLETA	JACKIE LAW Assistant Superintendent, Special Services Goleta Union School District 401 North Fairview Avenue Goleta, CA 93117	681-1220
GUADALUPE	ED CORA Superintendent Guadalupe Union School District 4465 Ninth Street, P.O. Box 788 Guadalupe, CA 93434-0788	343- 2114
HOPE	BRIAN MEDEL Special Education Coordinator/Psychologist Hope School District 3970 La Colina Road Santa Barbara, CA 93110	455-5885
LOMPOC	BOB ALTAVILLA Director, Special Education Lompoc Unified School District P.O. Box 8000 Lompoc, CA 93438-8000	742-3301
LOMPOC MTU & THE JONATA SATELLITE	LOIS KAM, PT, UNIT SUPERVISOR 991 Mountain View Blvd Suite 2 Vandenberg AFB, CA 93437	734-2005

ORCUTT	LANA THOMAS Director, Pupil Services Orcutt Union School District 500 Dyer Street Santa Maria, CA 93455	938-8960
SANTA BARBARA COUNTY EDUCATION OFFICE	CATHY BREEN Assistant Superintendent, Special Education Santa Barbara County Schools Office 4400 Cathedral Oaks Road Santa Barbara, CA 93111	964-4711
SANTA BARBARA MTU & THE CANALINO SATELLITE	JEANINE JOHNSON-CALOUDES OT, UNIT SUPERVISOR 4400 Cathedral Oaks Road Santa Barbara, CA 93110	967-7758
SANTA BARBARA SCHOOL DISTRICT	KERRI MILLS Assistant Superintendent Santa Barbara School District 720 Santa Barbara Street Santa Barbara, CA 93011	963-4338 x254
SANTA MARIA- BONITA SCHOOL DISTRICT	KAREN ANDERSON Director, Special Education Santa Maria-Bonita School District 708 South Miller Santa Maria, CA 93454	928-1783 x8180
SANTA MARIA HIGH SCHOOL DISTRICT	TINA CHRISTEN Director, Special Education Santa Maria Jt. Union High School District 2560 Skyway Drive Santa Maria, CA 93455	922-4573 x4221
SANTA MARIA MTU & THE BATTLES SATELLITE	ISABEL TELLEZ, PT UNIT SUPV. 601 W. Alvin Avenue Santa Maria, CA 93454	928-0662
SANTA YNEZ VALLEY CONSORTIUM	EMILY MILLER Director of Santa Ynez Valley Special Education Consortium Jonata School 301 Second Street Buellton, CA 93427-9476	688-4222 x2101

SELPA
COORDINATOR

CLAUDIA ECHAVARRIA
Santa Barbara County SELPA
401 N. Fairview Avenue

683-1424

SELPA
DIRECTOR

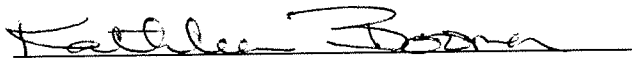
JARICE BUTTERFIELD
Santa Barbara County SELPA
401 N. Fairview Avenue
Goleta, CA 93117
Goleta, CA 93117

683-1424

INTERAGENCY AGREEMENT APPROVAL

INDEMNITY. Except as otherwise expressly provided, Santa Barbara California Children's Services and the Santa Barbara County SELPA shall defend, indemnify, and hold each other harmless from and against all claims, liability, loss, and expense, including reasonable costs, collection expenses and attorneys' fees incurred, which arise by reason of the acts of omissions of the indemnifying party, its agent or employees in the performance of its obligations under this agreement.

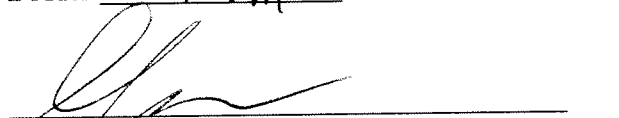
This agreement shall commence on the effective date of approval by the signatures. The agreement shall be reviewed annually and revised as necessary. It shall remain in effect until any revisions are mutually agreed upon or either party provides 20 days written notice to terminate.


KATHLEEN BOOMER, CHAIRPERSON
SANTA BARBARA COUNTY SELPA
JOINT POWERS AGENCY BOARD

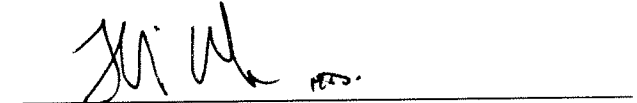
DATE 11/7/11


JARICE BUTTERFIELD, DIRECTOR
SANTA BARBARA COUNTY SELPA

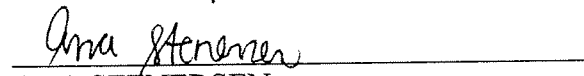
DATE 11/7/11


CLAUDIA ECHAVARRIA, COORDINATOR
SANTA BARBARA COUNTY SELPA
CCS THERAPY

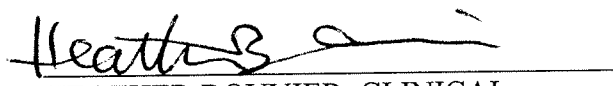
DATE 11/7/11


TAKASHI WADA, MD, MPH
DIRECTOR/ HEALTH OFFICER
SANTA BARBARA COUNTY
PUBLIC HEALTH DEPARTMENT

DATE 10/20/11


ANA STENERSEN
CHILDREN'S MEDICAL SERVICES
PROGRAM MANAGER

DATE 10/27/11


HEATHER BOUVIER, CLINICAL
EDUCATION COORDINATOR

DATE 11/1/11

California Children's Services Medical Eligibility for the Medical Therapy Program
22 CA ADC § 41517.5

22 CCR § 41517.5

Cal. Admin. Code tit. 22, § 41517.5

Barclays Official California Code of Regulations

Title 22. Social Security

Division 2. Department of Social Services -Department of Health Services

Subdivision 7. California Children's Services

Chapter 3. Client Application and Eligibility Requirements

Article 2. Medical Eligibility

→§ 41517.5. Medical Therapy Program.

(a) CCS applicants with at least one of the following conditions shall be medically eligible for participation in the CCS Medical Therapy Program:

(1) Cerebral palsy as specified in Section 41517.3(a)(2).

(2) Neuromuscular conditions that produce muscle weakness and atrophy, such as poliomyelitis, myasthenias, and muscular dystrophies.

(3) Chronic musculoskeletal and connective tissue diseases or deformities such as osteogenesis imperfecta, arthrogyrosis, rheumatoid arthritis, amputations, and contractures resulting from burns.

(4) Other conditions manifesting the findings listed in section 41517.3(a) above, such as ataxias, degenerative neurological disease, or other intracranial processes.

(b) CCS applicants under three years of age shall be eligible when two or more of the following neurological findings are present:

(1) Exaggerations of or persistence of primitive reflexes beyond the normal age (corrected for prematurity);

(2) Increased Deep Tendon Reflexes (DTRs) that are 3+ or greater;

(3) Abnormal posturing as characterized by the arms, legs, head, or trunk turned or twisted into an abnormal position;

(4) Hypotonicity, with normal or increased DTRs, in infants below one year of age. (Infants above one year must meet criteria described in (a)(1)); or

(5) Asymmetry of motor findings of trunk or extremities.

Overview of CCS Medical Eligibility

This brief summary document has been developed solely for the convenience and use in understanding the general medical eligibility criteria of the CCS program. It is not an authoritative statement of, and may not be cited as authority, for any decisions, determinations, or interpretations under the CCS program.

Please refer to the California Code of Regulations, Title 22, Division 2, Part 2, Subdivision 7, CCS, Chapter 4, Medical Eligibility, Sections 41800-41872 for full description. The applicable medical eligibility section is noted with each category below.

A. Infectious Diseases (ICD-9-CM 001-139) (Section 41811)

In general, these conditions are eligible when they:

- involve the central nervous system and produce disabilities requiring surgical and/or rehabilitation services;
- involve bone;
- involve eyes leads to blindness;
- are congenitally acquired and for which postnatal treatment is required and appropriate.

B. Neoplasms (ICD-9-CM 140-239) (Section 41815)

All malignant neoplasms, including those of the blood and lymph systems.

Benign neoplasms when they constitute a significant disability, visible deformity, or significantly interfere with function.

C. Endocrine, Nutritional, and Metabolic Diseases, and Immune Disorders (ICD-9-CM 240-279) (Section 41819)

In general, these conditions are eligible. Examples of eligible conditions include diseases of the pituitary, thyroid, parathyroid, adrenal, pancreas, ovaries and testes; growth hormone deficiency, diabetes mellitus, diseases due to congenital or acquired immunologic deficiency manifested by life-threatening complications, various inborn errors of metabolism; cystic fibrosis.

Nutritional disorders such as failure to thrive and exogenous obesity are not eligible.

D. Diseases of Blood and Blood-Forming Organs (ICD-9-CM 280-289) (Section 41823)

In general, these conditions are eligible. Common examples of eligible conditions are: sickle cell anemia, hemophilia, and aplastic anemia.

Iron or vitamin deficiency anemias are only eligible when there are life-threatening complications.

E. Mental Disorders and Mental Retardation (ICD-9-CM 290-319) (Section 41827)

Conditions of this nature are not eligible except when the disorder is associated with or complicates an existing CCS-eligible condition.

F. Diseases of the Nervous System (ICD-9-CM 320-389) (Section 41831)

Diseases of the nervous system are, in general, eligible when they produce physical disability (e.g., paresis, paralysis, ataxia) that significantly impair daily function.

Idiopathic epilepsy is eligible when the seizures are uncontrolled, as per regulations. Treatment of seizures due to underlying organic disease (e.g., brain tumor, cerebral palsy, inborn errors of metabolism) is based on the eligibility of the underlying disease.

Specific conditions not eligible are those which are self-limiting and include acute neuritis and neuralgia; and meningitis that does not produce sequelae or physical disability. Learning disabilities are not eligible.

G. Diseases of the Eye (ICD-9-CM 360-379) (Section 41835)

Strabismus is eligible when surgery is required.

Chronic infections or diseases of the eye are eligible when they may produce visual impairment and/or require complex management or surgery.

H. Diseases of the Ear and Mastoid (ICD-9-CM 380-389) (Section 41839)

Hearing loss, as defined per regulations;

- Perforation of the tympanic membrane requiring tympanoplasty;
- Mastoiditis;
- Cholesteatoma.

I. Diseases of the Circulatory System (ICD-9-CM 390-459) (Section 41844)

Conditions involving the heart, blood vessels, and lymphatic system are, in general, eligible.

J. Diseases of the Respiratory System (ICD-9-CM 460-519) (Section 41848)

Lower respiratory tract conditions are eligible if they are chronic, cause significant disability, and respiratory obstruction; or complicate the management of a CCS-eligible condition.

Lungs: chronic lung disease of infancy is eligible; chronic lung disease of immunologic origin is eligible, as per regulations.

K. Diseases of the Digestive System (ICD-9-CM 520-579) (Section 41852)

Diseases of the liver, chronic inflammatory disease of the gastrointestinal (GI) tract and most congenital abnormalities of the GI system are eligible; and gastroesophageal reflux, as per regulations.

Malocclusion is eligible when there is severe impairment of occlusal function and is subject to CCS screening and acceptance for care.

L. Diseases of the Genitourinary System (ICD-9-CM 580-629) (Section 41856)

Chronic genitourinary conditions and renal failure are eligible. Acute conditions are eligible when complications are present.

M. Diseases of the Skin and Subcutaneous Tissues (ICD-9-CM 680-709) (Section 41864)

These conditions are eligible if they are disfiguring, disabling, and require plastic or reconstructive surgery and/or prolonged and frequent multidisciplinary management.

N. Diseases of the Musculoskeletal System and Connective Tissue (ICD-9-CM 710-739) (Section 41866)

Chronic diseases of the musculoskeletal system and connective tissue are eligible. Minor orthopedic conditions such as toeing-in, knock knee, and flat feet are not eligible. However, these conditions may be eligible if expensive bracing, multiple casting, and/or surgery is required. See Q. below for acute injuries.

O. Congenital Anomalies (ICD-9-CM 740-759) (Section 41868)

Congenital anomalies of the various systems are eligible if the condition limits a body function, is disabling or disfiguring, amenable to cure, correction, or amelioration, as per regulations.

P. Perinatal Morbidity and Mortality (ICD-9-CM 760-779)

Neonates who have a CCS-eligible condition and require care in a CCS-approved neonatal intensive care unit (NICU) because of the eligible condition.

Critically ill neonates who do not have an identified CCS-eligible condition but who require one or more of the following services in a CCS-approved NICU:

- Invasive or non-invasive positive ventilatory assistance.
- Supplemental oxygen concentration by hood of greater than or equal to 40 percent.
- Maintenance of an umbilical artery (UA) or peripheral arterial catheter (PAC) for medically necessary indications, such as monitoring blood pressure or blood gases.
- Maintenance of an umbilical venous catheter or other central venous catheter for medically necessary indications, such as pressure monitoring or cardiovascular drug infusion.
- Maintenance of a peripheral line for intravenous pharmacological support of the cardiovascular system.
- Central or peripheral hyperalimentation.
- Chest tube.

Neonates and infants who do not have an identified CCS-eligible condition but who require two or more of the following services in a CCS-approved NICU:

- Supplemental inspired oxygen.
- Maintenance of a peripheral intravenous line for administration of intravenous fluids, blood, blood products or medications other than those used in support of the cardiovascular system.
- Pharmacological treatment for apnea and/or bradycardia episodes.
- Tube feedings.

Q. Accidents, Poisonings, Violence, and Immunization Reactions (ICD-9-CM 800-999) (Section 41872)

Injuries of the central or peripheral nervous and vital organs may be eligible if they can result in permanent disability or death. Fractures of the skull, spine, pelvis, or femur which when untreated would result in permanent loss of function or death. Burns, foreign bodies, ingestion of drugs or poisons, lead poisoning, and snake bites may be eligible, as per regulations.

Taken from <http://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility> on 8/8/11



Takashi M. Wada, MD, MPH Director/Health Officer
Anne M. Fearon Deputy Director
Suzanne Jacobson, CPA Chief Financial Officer
Michele Mickiewicz, MPH Deputy Director
Elizabeth Snyder, MHA Deputy Director
Peter Hasler, MD Medical Director

**L.E.A. REFERRALS
FOR CCS MEDICAL THERAPY PROGRAM SERVICES**

The following information and forms are required per section 60320 of CCR. Without this information, the CCS program will be unable to process the L.E.A. referral:

- () CCS Request for Service form: (HCS-255) which includes the required demographic and clinical information. Specify Medical Therapy Program and whether OT and/or PT are being requested.
- () CCS Application for Services completed by child's parent or legal guardian
- () Current medical records or a completed SELPA "Physician's Referral For Related Services" form that documents the child's medical diagnosis requiring occupational or physical therapy.
- () Parental permission for exchange of information between agencies
- () A copy of the current IEP or IFSP if the student is receiving special education services.

See the current Interagency Agreement between Santa Barbara County SELPA and Santa Barbara County CCS for details and forms.

If all of the above items are supplied with the referral, the L.E.A. will receive notice of action on determination of Medical Eligibility for CCS Therapy Services within 15 days from receipt of the referral

For questions, please contact the Coordinator for CCS Therapy Services at 681-5362.

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number
4. Address (number, street)		City State ZIP code
5. Contact person	6. Contact telephone number ()	7. Contact fax number ()

Client Information

8. Client name—last		first	middle
9. Alias (AKA)		10. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	11. Date of birth (mm/dd/yy)
12. CCS/GHPP case number	13. Contact phone number ()		14. Medical record number (hospital or office)
15. Residence address (number, street) (DO NOT USE P.O. BOX)		City	State ZIP code
16. Mailing address (if different) (number, street, P.O. box number)		City	State ZIP code
17. County of residence	18. Language spoken		19. Name of parent/legal guardian
20. Mother's first name	21. Primary care physician (if known)	22. Primary care physician telephone number ()	

Insurance Information

23.a. Enrolled in Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No		23.b. If yes, client index number (CIN)	23.c. Client's Medi-Cal number
24. Enrolled in Healthy Families <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of plan		
25. Enrolled in commercial insurance plan <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type of commercial insurance plan <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other	Name of plan	

Diagnosis

26. Diagnosis (DX)/ICD-9: _____ DX/ICD-9: _____ DX/ICD-9: _____

Requested Services

27.* CPT-4/ HCPCS Code/NDC	28. Specific Description of Service/Procedure	29. From (mm/dd/yy)	To (mm/dd/yy)	30. Frequency/ Duration	31. Units	32. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

33. Other documentation attached <input type="checkbox"/> Yes	34. Enter facility name (where requested services will be performed, if other than office).
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Inpatient Hospital Services

35. Begin date	36. End date	37. Number of days
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Additional Services Requested from Other Health Care Providers

38. Provider's name		Provider number	Telephone number ()	Contact person
Address (number, street)		City	State	ZIP code
Description of services		Procedure code	Units	Quantity
Additional information				
39. Provider's name		Provider number	Telephone number ()	Contact person
Address (number, street)		City	State	ZIP code
Description of services		Procedure code	Units	Quantity
Additional information				

40. Signature of physician/provider or authorized designee	41. Date
--	----------

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's CCS/GHPP number. If not known, leave blank.
13. Contact phone number: Enter the phone number where the client or client's legal guardian can be reached.
14. Medical record number: Enter the client's hospital or office medical record number.
15. Residence address: Enter the address of the client. Do not use a P.O. Box number.
16. Mailing address: Enter the mailing address if it is different than number 15.
17. County of residence: Enter residential county of the client.
18. Language spoken: Enter the client's language spoken.
19. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
20. Mother's first name: Enter the client's mother's first name.
21. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
22. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

- 23a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 23.b. and the client's Medi-Cal number in box 23.c.
24. Enrolled in Healthy Families: Mark the appropriate box. If the answer is yes, enter the name of the plan.
25. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

26. Diagnosis and/or ICD-9: Enter the diagnosis or ICD-9 code, if known, relating to the requested services.

Requested Services

27. CPT-4/HCPSC code/NDC: Enter the CPT-4, HCPSC code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
28. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
29. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
30. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
31. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
32. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
33. Other documentation attached: Check this box if attaching additional documentation.
34. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

35. Begin date: Enter the date the requested inpatient stay shall begin.
36. End date: Enter the end date for the inpatient stay requested.
37. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

38. and 39. Provider's name: Enter name of the provider you are referring services to.
Provider number: Enter the provider's provider number.
Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request.
Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

40. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
41. Date: Enter the date the request is signed.

INFORMATION ABOUT CALIFORNIA CHILDREN'S SERVICES (CCS)

What is California Children's Services?

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Care Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

What does CCS offer children?

If you or your child's doctor think that your child might have a CCS-eligible medical condition, CCS may pay for or provide a medical evaluation to find out if your child's condition is covered.

If your child is eligible, CCS may pay for or provide:

- Treatment, such as doctor services, hospital and surgical care, physical therapy and occupational therapy, laboratory tests, X-rays, orthopedic appliances and medical equipment.
- Medical case management to help get special doctors and care for your child when medically necessary, and referral to other agencies, including public health nursing and regional centers; or a
- Medical Therapy Program (MTP), which can provide physical therapy and/or occupational therapy in public schools for children who are medically eligible.

Who qualifies for CCS?

The program is open to anyone who:

- is under 21 years old;
- has or may have a medical condition that is covered by CCS;
- is a resident of California; and
- has a family income of less than \$40,000 as reported on the adjusted gross income on the state tax form or whose out-of-pocket medical expenses for a child who qualifies are **expected** to be more than 20 percent of family income; or the child has Healthy Families coverage.

Family income is not a factor for children who:

- need diagnostic services to confirm a CCS eligible medical condition; or
- were adopted with a known CCS eligible medical condition; or
- are applying only for services through the Medical Therapy Program; or
- have Medi-Cal full scope, no share of cost; or
- have Healthy Families coverage.

What medical conditions does CCS cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. There also may be certain criteria that determine if your child's medical condition is eligible. Listed below are categories of medical conditions that may be covered and **some examples** of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Disorders of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, PKU, diabetes)
- Disorders of the genito-urinary system (serious chronic kidney problems)
- Disorders of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Disorders of the sense organs (hearing loss, glaucoma, cataracts)
- Disorders of the nervous system (cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care

- Disorders of the skin and subcutaneous tissue (severe hemangioma)
- Medically handicapping malocclusion (severely crooked teeth)

Ask your county CCS office if you have questions.

What must the applicant or family do to qualify?

Families (or the applicant if age 18 or older, or an emancipated minor) must:

- complete the application form on page 3 and return it to their county CCS office;
- give CCS all of the information requested so CCS can determine if the family qualifies;
- apply to Medi-Cal if CCS believes that a family's income qualifies them for the Medi-Cal program. (If a family qualifies for Medi-Cal, the child is also covered by CCS. CCS approves the services; payment is made through Medi-Cal.)

How is my privacy protected?

California law requires that families applying for services be given information on how CCS protects their privacy.¹

To protect your privacy:

- CCS must keep this information confidential.²
- CCS may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and CCS records concerning you or your child. If you wish to see these records contact your county CCS office. By law, the information you give CCS is kept by the program.³

Do I have a right to appeal a decision?

You have the right to disagree with decisions made by CCS.⁴ This is called an appeal. The appeal process gives the parent/legal guardian or applicant a way to work with the CCS program to find solutions to disagreements. For information on the appeal process, contact your county CCS office.

Where can I get more information about CCS?

For more information, or help in filling out this application, please contact your county CCS office. Their phone number is usually listed in the government section of your local telephone directory. Look under California Children's Services or county Health Department.

Notes

1 Civil Code, Section 1798.17

2 In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250–6255)

3 Section 123800 et. seq. of the California Health and Safety Code

4 California Code of Regulations, Title 2, Chapter 13, Sections 42702–42703

INFORMACIÓN SOBRE LOS SERVICIOS PARA LOS NIÑOS DE CALIFORNIA (CCS)

¿Qué son los Servicios para los Niños de California?

CCS es un programa estatal que trata a niños con ciertas limitaciones físicas y con problemas y enfermedades de salud crónicas. CCS puede autorizar y pagar el costo de servicios y equipos médicos específicos provistos por especialistas aprobados por CCS. El Departamento de Servicios de Salud de California administra el programa CCS. Los condados de mayor tamaño operan sus propios programas CCS, mientras que los condados de menor tamaño comparten la operación de su programa con las oficinas regionales estatales de CCS en Sacramento, San Francisco y Los Angeles. El programa está financiado con fondos provenientes de impuestos estatales, del condado y federales, y con algunos honorarios que pagan los padres.

¿Qué ofrece CCS a los niños?

Si usted o el médico de su hijo piensa que su hijo puede tener un problema médico que cumple con los requisitos de CCS, es posible que CCS pague o provea una evaluación médica para determinar si el problema de su hijo está cubierto.

Si su hijo cumple con los requisitos, CCS podrá pagar o brindar:

- Tratamiento, como servicios médicos, cuidados en el hospital y de cirugía, fisioterapia y terapia ocupacional, pruebas de laboratorio, radiografías, aparatos ortopédicos y equipo médico.
- Manejo de casos médicos para ayudar a obtener médicos especialistas y cuidados para su hijo si son médicamente necesarios, así como remisión a otros organismos, incluyendo enfermería de salud pública y centros regionales.
- Programa de Terapia Médica (MTP, por sus siglas in inglés), que puede prestar servicios de fisioterapia y/o de terapia ocupacional en escuelas públicas para niños que cumplen con ciertos requisitos médicos.

¿Quiénes cumplen con los requisitos para CCS?

El programa está a disposición de todos los que:

- son menores de 21 años de edad;
- tienen o pueden tener un problema médico cubierto por CCS;
- son residentes de California y
- tienen un ingreso familiar de menos de \$40,000, según se informe en el ingreso bruto ajustado del formulario impositivo del estado o se **espera** que tendrán gastos médicos de bolsillo, para un niño que cumple con los requisitos, de más del 20 por ciento del ingreso familiar; o bien, el niño tiene cobertura de Healthy Families.

El ingreso familiar no es un factor determinante en el caso de los niños que:

- necesitan servicios diagnósticos para confirmar un problema médico que cumple con los requisitos de CCS; o
- fueron adoptados con conocimiento de que tenían un problema médico que cumple con los requisitos de CCS; o
- sólo están solicitando servicios mediante el Programa de Terapia Médica; o
- tienen Medi-Cal completo, sin compartir el costo; o
- tienen cobertura de Healthy Families.

¿Qué problemas médicos cubre CCS?

Sólo ciertos problemas están cubiertos por CCS. En general, CCS sólo cubre problemas médicos que causan impedimentos físicos o requieren servicios médicos, quirúrgicos o de rehabilitación. También puede haber ciertos criterios que determinan si el problema médico de su hijo cumple con los requisitos. La lista a continuación contiene las categorías de problemas médicos que pueden estar cubiertos y **algunos ejemplos** de cada uno de ellos:

- Problemas del corazón (enfermedad cardíaca congénita)
- Neoplasmas (cánceres, tumores)
- Enfermedades de la sangre (hemofilia, anemia de células falciformes)
- Enfermedades endocrinas, de nutrición y metabólicas (problemas de tiroides, PKU [fenilcetonuria], diabetes)
- Enfermedades del sistema genito-urinario (problemas crónicos serios de los riñones)
- Problemas del sistema gastrointestinal (enfermedad inflamatoria crónica, enfermedades del hígado)
- Defectos de nacimiento serios (paladar hendido, labio leporino, espina bífida)
- Enfermedades de los órganos sensoriales (pérdida del oído, glaucoma, cataratas)
- Enfermedades del sistema nervioso (parálisis cerebral, ataques no controlados)
- Enfermedades del sistema musculoesquelético y de los tejidos conectivos (artritis reumatoide, distrofia muscular)
- Enfermedades graves del sistema inmune (infección por el VIH)

- Problemas que causan impedimentos o intoxicaciones que requieren cuidados intensivos o rehabilitación (lesiones graves de la cabeza, el cerebro o la médula espinal, quemaduras graves)
- Complicaciones del nacimiento prematuro que requieren cuidados intensivos
- Enfermedades de la piel y del tejido subcutáneo (hemangioma grave)
- Mala oclusión que causa impedimentos médicos (dientes muy torcidos)

Si tiene preguntas, la oficina CCS de su condado se las puede responder.

¿Qué tiene que hacer el solicitante o la familia para cumplir con los requisitos?

Las familias (o el solicitante, si cumplió los 18 años o es un menor de edad emancipado) deben:

- completar el formulario de solicitud en la página 3 y enviarlo a la oficina CCS de su condado;
- dar a CCS toda la información solicitada, para que CCS pueda determinar si la familia cumple con los requisitos;
- solicitar Medi-Cal si CCS cree que el ingreso de la familia la habilita para registrarse en el programa Medi-Cal. (Si una familia califica para Medi-Cal, el niño también está cubierto por CCS. CCS aprueba los servicios y los pagos se efectúan mediante Medi-Cal).

¿Cómo se protege mi privacidad?

La ley de California requiere que se dé a las familias que soliciten servicios información sobre cómo CCS protege su privacidad.¹

Para proteger su privacidad:

- CCS tiene que mantener esta información confidencial.²
- CCS puede compartir la información que figura en el formulario con personal autorizado de otros programas de salud y bienestar **únicamente** si usted firmó un formulario de consentimiento.

Usted tiene derecho a ver su solicitud y los datos de CCS relativos a usted o a su hijo. Si desea ver estos datos, póngase en contacto con la oficina CCS de su condado. Por ley, la información que usted da a CCS es archivada por el programa.³

¿Tengo derecho a apelar una decisión?

Tiene derecho a estar en desacuerdo con las decisiones que tome CCS.⁴ Esto se llama hacer una apelación. El proceso de apelación permite que el padre, el tutor o el solicitante trabaje con el programa CCS para encontrar soluciones a los desacuerdos. Para información sobre el proceso de apelación, póngase en contacto con la oficina CCS de su condado.

¿Dónde puedo obtener más información sobre CCS?

Para más información o ayuda para llenar esta solicitud, póngase en contacto con la oficina CCS de su condado. Por lo general, el número de teléfono de dicha oficina figura en la sección de gobierno del directorio telefónico local. Busque bajo *California Children's Services* (Servicios para los Niños de California) o *County Health Department* (Departamento de Salud del condado).

Notas

- 1 Código Civil, Sección 1798.17
- 2 De conformidad con la Sección 41670, Título 22, Código de Reglamentaciones de California y la ley de Datos Públicos de California (Código de Gobierno, Secciones 6250–6255)
- 3 Sección 123800 et. seq. del Código de Salud y Seguridad de California
- 4 Código de Reglamentaciones de California, Título 2, Secciones 42702–42703

APPLICATION TO DETERMINE CCS PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term "applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. For instructions on completing this form, please see page 4. Please type or print clearly.

A. Applicant Information

1. Name of applicant (last) (first) (middle)		Name on birth certificate (if different)		Any other name the applicant is known by	
2. Date of birth (month, day, year)		3. Place of birth—county and state		Country, if born outside the U.S.	
4. Applicant's residence address (number, street) (do not use a P.O. box)			City	County	ZIP code
5. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		6. Race/ Ethnicity		7. Social security number (optional)	
8. What is the applicant's suspected eligible CCS condition or disability?					
9. Name of applicant's physician				10. Physician's phone number ()	

B. Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. Name(s) of parent or legal guardian		12. Mother's first name (if not identified in 11)		Maiden name	
13. Residence address (number, street) (do not use a P.O. box)			City	County	ZIP code
14. Mailing address (if different from 13)			City	ZIP code	
15. Day phone number ()	16. Evening phone number ()	17. Message phone number ()		18. What language do you speak at home?	

C. Health Insurance Information

19. Does the applicant have Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what is the applicant's Medi-Cal number?		Is there a share-of-cost? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what amount do you pay per month? \$	
20. Is the applicant enrolled in the Healthy Families program? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what is the name of the plan?					
21. Does the applicant have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what is the name of the insurance plan or company?					
Type of insurance plan or company <input type="checkbox"/> Preferred Provider (PPO) <input type="checkbox"/> Health Maintenance Organization (HMO) <input type="checkbox"/> Other: _____							
22. Does the applicant have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				23. Does the applicant have vision insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			

D. Certification (Initial and sign below. Your signature authorizes the CCS program to proceed with this application.)

___ I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of the applicant by the CCS program.

___ I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

___ I certify that I have read and understand the information or have had it read to me.

___ I also certify that the information I have given on this form is true and correct.

Signature of person completing the application		Relationship to the applicant		Date
Signature of witness (only if the person signed with a mark)				Date

Mail this form to your county CCS office.

SOLICITUD PARA DETERMINAR SI EL SOLICITANTE PUEDE PARTICIPAR EN EL PROGRAMA CCS

Esta solicitud debe ser completada por el padre, el tutor o el solicitante (si cumplió los 18 años de edad o es un menor de edad emancipado) para determinar si el solicitante cumple con los requisitos para recibir servicios y beneficios de CCS. El término "solicitante" significa el niño, la persona de 18 años de edad o más o el menor de edad emancipado para el que se solicitan los servicios. Para obtener instrucciones sobre cómo completar este formulario, consulte la página 4. Escriba a máquina o claramente en letras de molde.

A. Información sobre el solicitante

1. Nombre del solicitante [apellido] [nombre] [segundo nombre] ; Nombre en el certificado de nacimiento (si es diferente)		; Algún otro nombre por el que se conoce al solicitante	
2. Fecha de nacimiento (mes, día, año) ____/____/____		3. Lugar de nacimiento, condado y estado ; País, si nació fuera de EE.UU.	
4. Dirección del solicitante (número y calle) (no usar casilla postal)		Ciudad	Condado ; Código postal
5. Género <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino		6. Raza/ etnia ; 7. Número del seguro social (optativo) _____	
8. ¿Cuál es el problema o la discapacidad del solicitante que se sospecha que cumple con los requisitos de CCS?			
9. Nombre completo del médico del solicitante		10. Número de teléfono del médico ()	

B. Información sobre el padre o tutor (los solicitantes de 18 años de edad o mayores o los menores emancipados saltean los números 11 y 13).

11. Nombre(s) completo(s) del/de los padre(s) o tutor(es)		12. Nombre de la madre (si no se identificó en 11) ; Apellido de soltera	
13. Dirección (número y calle) (no usar casilla postal)		Ciudad	Condado ; Código postal
14. Dirección postal (si no es la misma que la del 13)		Ciudad	Código postal
15. N° de teléfono diurno ()	16. N° de teléfono nocturno ()	17. N° para mensajes telefónicos ()	18. ¿Qué idioma se habla en su casa?

C. Información sobre el seguro de salud

19. ¿Tiene Medi-Cal el solicitante? <input type="checkbox"/> Sí <input type="checkbox"/> No		; Si tiene, ¿cuál es el número de Medi-Cal del solicitante?		; ¿Comparte el costo? <input type="checkbox"/> Sí <input type="checkbox"/> No		; Si lo comparte, ¿cuánto paga por mes? \$	
20. ¿Está inscrito el solicitante en el programa Healthy Families? <input type="checkbox"/> Sí <input type="checkbox"/> No		; Si lo está, ¿cómo se llama el plan?					
21. ¿Tiene el solicitante otro seguro de salud? <input type="checkbox"/> Sí <input type="checkbox"/> No		; Si lo tiene, ¿cómo se llama el plan o la compañía de seguros?					
Tipo de plan o compañía de seguros <input type="checkbox"/> Proveedor Preferente (PPO) <input type="checkbox"/> Organización para el Mantenimiento de la Salud (HMO) <input type="checkbox"/> Otro: _____							
22. ¿Tiene seguro dental el participante? <input type="checkbox"/> Sí <input type="checkbox"/> No				23. ¿Tiene seguro de la vista el solicitante? <input type="checkbox"/> Sí <input type="checkbox"/> No			

D. Certificación (Coloque sus iniciales y firme a continuación. Su firma autoriza al programa CCS a proceder con esta solicitud).

___ Solicito el programa CCS para determinar el cumplimiento de requisitos para obtener servicios y beneficios. Entiendo que completar esta solicitud no garantiza la aceptación del solicitante en el programa CCS.

___ Doy permiso para que se verifique mi dirección, información sobre la salud u otras circunstancias que se requieran para determinar el cumplimiento de requisitos para recibir servicios y beneficios CCS.

___ Certifico que he leído y comprendo la información o que me la han leído.

___ También certifico que la información que escribí en este formulario es verdadera y correcta.

Firma de la persona que llenó la solicitud		Relación con el solicitante	Fecha
Firma del testigo (sólo si la persona firmó con una marca)			Fecha

Envíe este formulario por correo a la oficina CCS de su condado. Consulte la página 6 para obtener una lista de direcciones.

INSTRUCTIONS FOR COMPLETING THE CALIFORNIA CHILDREN'S SERVICES APPLICATION FORM (DHCS 4480)

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, please contact your county CCS office.

Once the application is completed, mail it to your county CCS office (see page 6). Remember to sign and date the form.

Section A: Applicant Information ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested.)

1. **Applicant's name:** Fill in the applicant's last, first, and middle name. In the next box, write the applicant's full name as it appears on his/her birth certificate if different from his/her name. If the applicant is known by any other name, please include that name in the last box.
2. **Applicant's date of birth:** Write the month, day, and year of the applicant's birth.
3. **Place of birth:** Write the county and state where applicant was born. Include the country if the applicant was born outside the U.S.
4. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Please do not use a P.O. box.
5. **Applicant's gender:** Place a checkmark or an X in the correct gender box (male or female).
6. **Race/Ethnicity:** Please enter the category from the following list which best describes the applicant's primary race/ethnicity:
 - Alaskan Native
 - Amerasian
 - American Indian
 - Asian
 - Asian Indian
 - Black/African American
 - Cambodian
 - Chinese
 - Filipino
 - Guamanian
 - Hawaiian
 - Hispanic/Latino
 - Japanese
 - Korean
 - Laotian
 - Samoan
 - Vietnamese
 - White
 - Other
7. **Applicant's social security number (optional):** Please write the applicant's nine-digit social security number.
8. **Suspected CCS condition or disability:** Write down the applicant's disability or special health care need that would be treated by CCS. The enclosed description of CCS eligible conditions may help you (see "What medical conditions does CCS cover" on page 1). If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.
9. **Name of applicant's physician:** Write the name of the applicant's physician.
10. **Physician's phone number:** Write the phone number for the physician listed in number 9.

Section B: Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. **Parent/guardian name(s):** Write the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).
12. **Mother's first name and maiden name:** Write the applicant's mother's first name and maiden name.
13. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of your current residence. Please do not use a P.O. box.
14. **Mailing address:** If this address is different from number 13, please write the street number, street name, city, and ZIP code.
15. **Daytime phone number:** Please write the phone number where you can be reached during the day.
16. **Evening phone number:** Please write the phone number where you can be reached during the evening.
17. **Message phone number:** Please write your message phone number if applicable.
18. **Language(s) spoken:** Write down the language you speak at home.

Section C: Health Insurance Information

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

19. If the applicant does not receive Medi-Cal, check "No" and go to number 20. If the applicant receives Medi-Cal, check "Yes" and fill in the applicant's Medi-Cal number. If you pay a portion of the cost of your Medi-Cal insurance, check "Yes" and fill in the amount of your shared cost. If you don't, check "No" and go to number 20.
20. If the applicant receives health insurance from the Healthy Families program please check "Yes" and fill in the name of the plan. If the applicant does not, check "No." Healthy Families is a special health insurance program for moderate to low income families. If you think you might qualify, you can ask your county CCS program about how to apply for the Healthy Families program.
21. If the applicant does not have other health insurance, check "No" and go to number 22. If the applicant has health insurance, check "Yes" and fill in the name of the insurance plan or company. Then check the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, you can call your health insurance company and ask them.
22. If the applicant has dental insurance, check "Yes." If the applicant does not have dental insurance, check "No."
23. If the applicant has vision insurance, check "Yes." If the applicant does not have vision insurance, check "No."

Section D: Certification

Be sure to sign and date in ink. If signature is signed with a mark, please have a witness sign his or her signature and fill in the date.

Under "Relationship to the applicant," enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).

Submitting Your Application

Mail or deliver your application to your county CCS office. To find your county CCS office, go to www.dhcs.ca.gov/services/ccs or look in the government section of your local telephone directory under California Children's Services or county health department.

**INSTRUCCIONES PARA COMPLETAR EL FORMULARIO
PARA SOLICITAR SERVICIOS PARA NIÑOS DE CALIFORNIA (DHCS 4480)**

Escriba claramente en letras de molde para que su solicitud se pueda tramitar lo más rápidamente posible.

Llene cada sección completamente. Si no da toda la información, CCS no podrá proceder con su solicitud. Si necesita ayuda para llenar este formulario, póngase en contacto con la oficina CCS de su condado.

Después de completar la solicitud, envíela por correo a la oficina CCS de su condado (consulte la página 6). No olvide firmar el formulario y colocarle la fecha.

Sección A: Información sobre el solicitante ("Solicitante" significa el niño, la persona de 18 años de edad o mayor, o el menor de edad emancipado para el que se solicitan los servicios).

1. **Nombre del solicitante:** Escriba el apellido, el nombre y el segundo nombre del solicitante. En la casilla que sigue, escriba el nombre completo del solicitante como aparece en su certificado de nacimiento si no es igual a su nombre. Si el solicitante se conoce por cualquier otro nombre, escriba ese nombre en la última casilla.
2. **Fecha de nacimiento del solicitante:** Escriba el mes, el día y el año del nacimiento del solicitante.
3. **Lugar de nacimiento:** Escriba el condado y el estado en los que nació el solicitante. Si el solicitante nació fuera de EE.UU., escriba el país.
4. **Dirección:** En este espacio, escriba el número de la calle, el nombre de la calle, el número del departamento, la ciudad, el condado y el código postal del lugar donde vive ahora el solicitante. No use ninguna casilla de correo.
5. **Género del solicitante:** Ponga una marca o una X en la casilla que corresponda al género (masculino o femenino).
6. **Raza o etnia:** Ponga la categoría de la lista que aparece más abajo que mejor describa la raza o etnia principal del solicitante:
 - Nativo de Alaska
 - Amerasiático
 - Indígena norteamericano
 - Asiático
 - Indio asiático
 - Negro/afroamericano
 - Camboyano
 - Chino
 - Filipino
 - Guaymeño
 - Hawaiano
 - Hispano/latino
 - Japonés
 - Coreano
 - Laosiano
 - Samoano
 - Vietnamita
 - Blanco
 - Otro
7. **Número del seguro social del solicitante (optativo):** Escriba el número de nueve cifras del seguro social del solicitante.
8. **Problema o discapacidad que se sospecha que cumple con los requisitos de CCS:** Escriba la discapacidad o la necesidad especial de atención de la salud del solicitante que trataría el CCS. La descripción adjunta de los problemas que cumplen con los requisitos de CCS lo puede ayudar (consulte "¿Qué problemas médicos cubre CCS?" en la página 1). Si no sabe, pregunte al médico del solicitante o deje el espacio en blanco. Si hace falta más información, CCS se pondrá en contacto con el médico del solicitante.
9. **Nombre completo del médico del solicitante:** Escriba el nombre completo del médico del solicitante.
10. **Número de teléfono del médico:** Escriba el número de teléfono del médico que puso en el número 9.

Sección B: Información sobre el padre o tutor (Los solicitantes de 18 años de edad o mayores o los menores de edad emancipados saltean los números 11 y 13).

11. **Nombres completo(s) del/de los padre(s) o tutor(es):** Escriba el/los nombre(s) del/de los padre(s) del solicitante o del/de los tutor(es) del solicitante.
12. **Nombre y apellido de soltera de la madre:** Escriba el nombre y el apellido de soltera de la madre del solicitante.
13. **Dirección:** Escriba el número de la calle, el nombre de la calle, el número del departamento, la ciudad, el condado y el código postal del lugar en que usted vive ahora. No use ninguna casilla de correo.
14. **Dirección postal:** Si la dirección es diferente de la del número 13, escriba el número de la calle, el nombre de la calle, la ciudad y el código postal.
15. **Número de teléfono diurno:** Escriba el número de teléfono al que se lo puede llamar durante el día.
16. **Número de teléfono nocturno:** Escriba el número de teléfono al que se lo puede llamar durante la noche.
17. **Número para mensajes telefónicos:** Si corresponde, escriba el número de teléfono para dejarle mensajes telefónicos.

18. **Idioma(s) que habla:** Escriba el idioma que usted habla en su casa.

Sección C: Información sobre el seguro de salud

Si CCS cree que usted puede cumplir con los requisitos de participación, le pedirán que solicite Medi-Cal si en la actualidad no está recibiendo beneficios Medi-Cal para la atención de la salud.

19. Si el solicitante no recibe Medi-Cal, marque "No" y pase al número 20. Si el solicitante recibe Medi-Cal, marque "Sí" y escriba el número de Medi-Cal del solicitante. Si usted paga una parte del costo de su seguro Medi-Cal, marque "Sí" y escriba la cantidad del costo que comparte. De lo contrario, marque "No" y pase al número 20.
20. Si el solicitante recibe seguro de salud del programa Healthy Families, marque "Sí" y escriba el nombre del plan. Si el solicitante no recibe ese seguro, marque "No". Healthy Families es un programa de seguro especial para las familias de ingresos moderados a bajos. Si le parece que puede cumplir con los requisitos, pregúntele al programa CCS de su condado cómo puede solicitar participar en el programa Healthy Families.
21. Si el solicitante no tiene otro seguro de salud, marque "No" y pase al número 22. Si el solicitante tiene seguro de salud, marque "Sí" y escriba el nombre del plan o de la compañía de seguros. Después marque la casilla que corresponda, dependiendo de la clase de seguro que sea. Sus formularios de seguros le indican la clase de seguro de salud que tiene. Si no está seguro puede llamar a su compañía de seguros y preguntarles.
22. Si el solicitante tiene seguro dental, marque "Sí". Si el solicitante no tiene seguro dental, marque "No".
23. Si el solicitante tiene seguro de la vista, marque "Sí". Si el solicitante no tiene seguro de la vista, marque "No".

Sección D: Certificación

Asegúrese de firmar y poner la fecha con tinta. Si firma con una marca, pida a un testigo firme y ponga la fecha.

En la sección "Relación con el solicitante", coloque padre, madre, tutor o sí mismo (en el caso de las personas de 18 años de edad o mayores, de los menores de edad emancipados).

Presentación de su solicitud

Envíe por correo o entregue su solicitud a la oficina CCS de su condado. Para encontrar la oficina CCS de su condado visite www.dhcs.ca.gov/services/ccs o busque en la sección de gobierno del directorio telefónico local bajo *California Children's Services* (Servicios para los Niños de California) o *County Health Department* (Departamento de Salud del condado).

AUTHORIZATION FOR RELEASE OF INFORMATION

These records are protected under federal regulations governing confidentiality of patient records (42 CFR Section 2.1, 45 CFR Parts 160 and 164), and California regulations governing privacy of health information (Civil Code 56.10-56.38, Health & Safety Code 123100-123149.5, and Welfare and Institutions Code 5328).

RE: _____ DOB: / / CCS# _____

I, the undersigned, hereby consent to, request and authorize the use and disclosure of medical and educational records between California Children Services, Santa Barbara Public Health Department, and those individuals and agencies listed below who have provided or are providing medical or educational services to the above named person.

I understand that these records will be used only to coordinate medical and educational services to the above named person and that California Children Services protects the confidentiality of client information and releases information only according to policies based on federal and state law.

Does the above named person receive special education services or have an Individual Educational Plan (IEP)? Yes No
 Does he/she receive Early Start services or have an Individual Family Service Plan (IFSP)? Yes No

MEDICAL PROVIDERS		
Name of Primary Care Physician	Address/City/Zip	Phone Number
Name of Other Medical Providers	Address/City/Zip	Phone Number
EDUCATIONAL PROVIDERS		
School District/Local Education Agency	Address/City/Zip	Phone Number
TRI-COUNTIES REGIONAL CENTER		
Name of Service Coordinator	Address/City/Zip	Phone Number
OTHER AGENCIES (Name)		
Name of Service Coordinator	Address/City/Zip	Phone Number

I understand that the County does not condition my eligibility, enrollment, treatment or benefits based upon signing this **Authorization for Release of Information**. I understand that there is the potential for this information to be disclosed by the recipient and that the County is not responsible for other providers' or agencies' use and disclosure. I have the right to inspect, obtain copies, or amend the health information that I am authorizing California Children's Services to disclose.

I understand that this **Authorization for Release of Information** is valid until the above named person turns 21 years of age or until their California Children Services case is closed (whichever comes first). All or part of the **Authorization for Release of Information** may be canceled upon receipt of written notification from the undersigned to the address listed above.

A copy of this **Authorization for Release of Information** is as valid as the original. The person signing this consent has the right to obtain a copy.

Name of Parent/Legal Guardian:(Client if over age 18): _____

Signature of Parent/Legal Guardian (Client if over age 18): _____ Date: _____

Signature of Witness: _____ Date: _____

Revised 05/23/05

AUTORIZACION PARA CEDER INFORMACION MEDICA

Estos expedients son protegidos bajo los reglamentos federales gobernando la confidencialidad de los archivos medicos del paciente (42 CFR Seccion 2.1, 45 CFR partos 160 y 164), y los reglamentos de California gobernando la privacidad de información médica (Civil Code 56.10-56.38, Health & Safety Code 123100-123149.5, and Welfare and Institutions Code 5328).

RE: _____ FDN: _____ CCS#: _____

Yo, el abajo firmante, por la presente doy mi consentimiento que soliciten y autorizo el uso y revelación de mi expediente médico y educativo entre Servicios de los Niños de California, el Departamento de Salud Pública de Santa Bárbara, y los individuos y agencias que figuran abajo que han dado o esten dando servicios medicos o educativos a la persona que figura arriba.

Entiendo que estos expedients serán usados para coordinar los servicios medicos y educacionales de la persona que figura arriba y que el Servicio de los Niños de California protège la confidencialidad de la información del cliente y revela solamente información de acuerdo con las polizas basadas en la ley federal y estatal de California.

¿La persona que figura arriba recibe servicios de educación especial o tiene un Plan Educativo Individual? Sí No
 ¿Recibe el/ella servicios de primeras etapar (Early Start) o el plan de Servicio Individual de Familia? Sí No

PROVEEDORES MEDICOS		
Nombre de su Médico Particular	Domicilio/Ciudad/Código Postal	Número de teléfono
Nombre de Otros Proveedores Médicos	Domicilio/Ciudad/Código Postal	Número de teléfono
PROVEEDORES EDUCATIVOS		
Distrito Escolar/Agencia Local de Educación	Domicilio/Ciudad/Código Postal	Número de teléfono
EL CENTRO REGIONAL DE LOS TRES CONDADOS		
Nombre del Coordinador de Servicios	Domicilio/Ciudad/Código Postal	Número de teléfono
OTRAS AGENCIAS (Nombre)		
Nombre del Coordinador de Servicios	Domicilio/Ciudad/Código Postal	Número de teléfono

Entiendo que el Condado no acondiciona mi elegibilidad, inscripción, tratamiento o beneficios al firmar esta **Autorización para Ceder Información Médica**. Entiendo que esta información ya en poder de Agencias o profesionales Medicos, potencialmente pudiera ser desiminada y que el Condado de Santa Bárbara no es responsable por el uso o desiminación de información por parte de otras agencias, instituciones y profesionales de salud. Y tengo el derecho de inspeccionar, obtener copias, amendar la información médica que yo autorizo al Servicio de los Niños de California que puedan reveler.

Entiendo que esta **Autorización para Ceder Información Médica** es valida hasta que la persona que figura arriba llegue a la edad de 21 años o hasta que se cierre el caso bajo los Servicios de los Niños de California (cual llegue primero). Toda o parte de la **Autorización para Ceder Información Médica** puede ser cancelada al recibir por escrito notificación del abajo firmante al domicilio que figura arriba.

Una copia del la **Autorización para Ceder Información Médica** es tan válida como la original. El abajo firmante de este consentimiento tiene el derecho de obtener una copia.

Nombre del padre/Tutor Legal (o el Cliente si es mayor de 18 años): _____

Firma del Padre/Tutor Legal (o el Cliente si es mayor de 18 años): _____ Fecha: _____

Firma de Testigo: _____ Fecha: _____

Santa Barbara County
 Special Education Local Plan Area _____ *A Joint Powers Agency*

PHYSICIAN'S INFORMATION FORM FOR RELATED SERVICES

PART I: TO BE COMPLETED BY PARENT OR SCHOOL DISTRICT PERSONNEL

CHILD'S LEGAL NAME: *Last* _____ *First* _____ *Middle* _____ *Date of Birth* _____

ADDRESS: *Number* _____ *Street* _____ *City* _____ *Zip* _____ *Telephone* _____

MOTHER'S NAME: *Last* _____ *First* _____ *Middle* _____ **FATHER'S NAME:** *Last* _____ *First* _____ *Middle* _____

PARENT'S ADDRESS: *(If different from above)* _____ **PHONE:** *Home* _____ *Daytime* _____

NAME OF PERSON MAKING REFERRAL: _____

RELATIONSHIP TO CHILD: _____ **DAYTIME PHONE:** _____

HAS THIS CHILD BEEN REFERRED TO REGIONAL CENTER (TCRC)? NO YES

IS THIS CHILD A CLIENT OF TCRC? NO YES

THE COMPLETED FORM SHOULD BE RETURNED TO:

NAME: _____ **DISTRICT/COUNTY OFFICE:** _____

ADDRESS: _____
Street _____ *City* _____ *Zip* _____

PART II: TO BE COMPLETED BY THE PHYSICIAN *(See directions below)*

1. DIAGNOSIS OR SUSPECTED CONDITION(S): Please include all disabling conditions and a short description of each

2. MEDICATIONS: _____

3. PRECAUTIONS/CONTRADICTIONS: _____

 Physician Signature _____ Date _____

 Physician Printed Name _____

() _____

 Address _____

 Telephone _____

DIRECTIONS FOR COMPLETION OF SELPA 16

To District Personnel: Part I of the Physician's Form for Related Service must be completed by the District or parent before being submitted to the physician. It is recommended that Part I and Part II of this form be completed and included in the CCS referral packet but it is not required. This is a District responsibility. For referrals to CCS, a CCS Request for Services, CCS Application for Services, and Parent Release of Information form must also be provided. **To the Physician:** Please complete Part II and return the completed information to the District/County Office listed in Part I of this form. Thank you.



Takaahi M. Wada, MD, MPH *Director/Health Officer*
Anne M. Fearon *Deputy Director*
Suzanne Jacobson, CPA *Chief Financial Officer*
Michele Mickiewicz, MPH *Deputy Director*
Elizabeth Snyder, MHA *Deputy Director*
Peter Hasler, MD *Medical Director*

MEDICAL ELIGIBILITY NOTIFICATION

To: _____

Date: _____

Re: Child _____

Birth date: _____

Dear Parent/Legal Guardian:

Your child has been determined to be medically eligible for the California Children Services (CCS) Medical Therapy Program (MTP). Within fifteen days you will be contacted by the therapy staff at the following Medical Therapy Unit to schedule an appointment for an initial (physical or occupational) therapy assessment/evaluation.

**Lompoc Medical Therapy Unit
Mountain View Blvd
Vandenberg AFB, CA 93437
(805) 734-2005
Unit Supervisor: Lois Kam, PT**

If you have not heard from the MTU within this time period, please contact the Unit Supervisor listed.

If you have any questions, please feel free to contact 681-5362.

Coordinator, CCS Therapy Services

cc: LEA
MTU
Referring MD

RR4L

CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County CCS Office
345 Camino Del Remedio, 3rd Fl
Santa Barbara, CA 93110
(805) 681-5360

Original

Client Name: :
Birth Date:
Case #:
County: Santa Barbara
CIN #:

NOTICE OF ACTION (NOA)

Dear

This is a Notice of Action. We call it NOA for short. This NOA is to tell you that your referral, services or eligibility to California Children's Services is denied as of .

This will not affect your child's Medi-Cal or Healthy Families benefits, if applicable.

Your child's health is important to us, but you have not met CCS program requirements, therefore, CCS eligibility cannot be approved.

There is no documentation of medical eligibility for the CCS Medical Therapy Program (MTP) at this time. Eligibility for the MTP is therefore denied.

Citations: Health and Safety Code 123830; California Code of Regulations, Title 2, Section 60300(j); California Code of Regulations, Title 22, Sections 41515.1, 41517.3, and 41517.5.

If you disagree with this decision, you may appeal. The deadline to appeal is . . . , which is 30 days from the date of this NOA. Read the enclosed information to learn more about your right to appeal.

If you have questions, or would like to give us more information, please call Santa Barbara County CCS Office at (805) 681-5360.

Sincerely,

California Children's Services

5007591-2011

Included with this letter:

How to Appeal

This NOA is required by California Code of Regulations, Title 22, Sections 42140 and 42160.

We sent a copy of this letter to:

CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County CCS Office
345 Camino Del Remedio, 3rd Fl
Santa Barbara, CA 93110
(805) 681-5360

How to Appeal

*** What is an appeal?**

An appeal is a way to ask us to reconsider our decision. The parent, the applicant, the legal guardian or an authorized representative can ask for an appeal.

*** How do I ask for an appeal?**

The CCS Family Handbook has more information about appeals.

Send us a letter asking for an appeal. In your letter say why you disagree with our decision. If you want to continue the services your child is getting now, say that in your letter. Please supply all pertinent documentation that supports your appeal.

*** Is there a deadline?**

Yes. We must receive your appeal within 30 calendar days of the date on the attached NOA letter.

*** Can CCS help me with my appeal?**

Yes. If you have questions or need help, contact your county's CCS office:

Santa Barbara County CCS Office
345 Camino Del Remedio, 3rd Fl
Santa Barbara, CA 93110
(805) 681-5360

Your local Family Resource Center can also provide information and support regarding the CCS appeal process.

For information on how to contact the nearest Family Resource Center, call 1-800-515-BABY or go to the Family Voices of California website at www.familyvoicesofca.org.

Parent Training and Information Centers may also be able to provide support (www.cde.ca.gov/sp/se/qa/capmtorg.asp).

Appeal Rights

*** Where can I learn about the laws for appeals?**

See the California Code of Regulations, Title 22, Sections 42140 and 42160.

You can read the law at: <http://ccr.oal.ca.gov>

*** Where do I send my appeal?**

Mail or deliver your appeal to:

Santa Barbara County CCS Office
345 Camino Del Remedio, 3rd Fl
Santa Barbara, CA 93110

Keep a copy of the appeal for your records.

*** When will my appeal be decided?**

We will send you a copy of the decision on your appeal within 20 days.



Takashi M. Wada, MD, MPH Director/Health Officer
 Anne M. Fearon Deputy Director
 Suzanne Jacobson, CPA Chief Financial Officer
 Michele Micklewicz, MPH Deputy Director
 Elizabeth Snyder, MHA Deputy Director
 Peter Hasler, MD Medical Director

**PROGRAMA DE TERAPIA MÉDICA (MTP)
 PLAN DE ASESORAMIENTO DE TERAPIA**

TERAPIA FÍSICA ___ TERAPIA OCUPACIONAL ___

NOMBRE: _____ FECHA DE NACIMIENTO: _____ CCS #: _____

Su niño ha sido referido al programa de terapia médica de CCS para un asesoramiento físico y/o ocupacional de terapia necesarios. Los instrumentos siguientes del asesoramiento serán utilizados para permitir que el terapeuta desarrolle un plan preestablecido de terapia.

- ___ OBSERVACIONES CLINICOS: Las observaciones del terapeuta del niño durante el asesoramiento.
- ___ ACTIVIDADES DE LA VIDA DIARIA: Habilidades funcionales tales como la movilidad, las transferencias, movimiento, paso, el comer, vestirse, bañarse, asearse, las necesidades, habilidades caseras y uso de equipo adaptado.
- ___ MOVILIDAD: Manera de la cual el niño se mueve en su medio ambiente.
- ___ AMPLITUD DE MOVIMIENTO: Prueba estandarizada del alcance pasivo y activo de las coyunturas.
- ___ SENSORIAL: Reacción a la posición en espacio, la identificación del objeto, discriminación de 2 puntos, y táctil (afilado/no afilado).
- ___ MOTOR FINO: Madurez del motor con respuestas apropiadas para la edad.
- ___ MOTOR GRUESO: Madurez del motor con respuestas apropiadas para la edad.
- ___ REFLEJOS: Reacciones de postura, equilibrio y reacciones al equilibrio.
- ___ ALINEAMIENTO POSTURAL: Postura como se relaciona con el sistema esquelético y las capacidades funcionales.
- ___ MOTOR ORAL: Examen de la cavidad bucal, de los reflejos orales/faciales y de los músculos.
- ___ PERCEPCION: Prueba estandarizada de la capacidad del niño en recibir, interpretar y utilizar impresiones sensoriales.
- ___ RESPIRATORIO: Prueba estandarizada de la capacidad vital.
- ___ OTRO:

Terapeuta _____ Fecha _____
 _____ MTU

Terapeuta _____ Fecha _____
 Dirección: _____

POR FAVOR FIRME ABAJO Y DEVUELVA ESTE FORMULARIO LO ANTES POSIBLE A LA DIRECCION QUE SE ENCUENTRA EN EL CABEZAL DE LA HOJA. EL CONSENTIMIENTO FIRMADO SE DEBE DAR ANTES DE INICIAR EL ASESORAMIENTO ANTEDICHO.

Doy por este medio el consentimiento para que mi niño sea evaluado en cualesquiera de las áreas marcadas arriba.

Padre/Guardián _____

Fecha _____

RR5 cc: ___ parent/guardian ___ LEA/SELPA ___ CCS office ___ MTU file

To the Parents of:
Lompoc, Ca 93436

Dear Parents,

The Lompoc Medical Therapy Unit has scheduled an appointment for your child to be seen at our next **MEDICAL THERAPY CONFERENCE/CLINIC** on:

**Wednesday - August 24th, 2011 at 10:40 a.m. to see
, MD – Orthopedist**

At the: **Lompoc Medical Therapy Unit**
991 Mountain View Blvd. Suite 2
Vandenberg AFB, CA 93436

As clinic appointments are limited, please make every attempt to keep this appointment. As a result of the Medical Therapy Conference, you child's Occupational and/or Physical Therapy Treatment Plan may be modified or placed on hold.

Please call to confirm the above appointment no later than *Tuesday, August 16th* at 734-2005.

Feel free to invite your Early Start or Tri-Counties Regional Center Service Coordinator or your child's teacher to attend this appointment with you. The Medical Therapy Conference/Clinic is a free CCS program benefit that does not require financial eligibility. The occupational and physical therapy services prescribed by the Medical Therapy Conference team are also free of charge. Any X-rays, bracing, durable medical equipment, or other medical services or surgeries recommended by the team will require financial eligibility to be authorized by the CCS program.

Since it may be necessary to undress your child for examination purposes, he/she may feel more comfortable in shorts or a bathing suit worn underneath regular clothing. Please bring a list of current medication, any bracing, splints, or assistive devices (walker, crutches, wheelchair) currently being used by your child.

Your questions and concerns regarding your child and their therapy program are important, so please list them below and bring this letter with you to this clinic.

1. _____
2. _____
3. _____

Sincerely,

Monica V. Santana
Administrative Office Professional
California Children Services-Lompoc MTU

Sobre:
FDN:

Estimados/as:

La oficina de la Unidad de Terapia de Santa Barbara a hecho una cita para su niño/a para nuestra próxima Conferencia/Clinica de Terapia Médica en:

Fecha:

Hora:

Doctore(s):

Lugar:

Santa Barbara Medical Therapy Unit
4400 Cathedral Oaks Road
Santa Barbara, CA 93110

La Conferencia/Clinica de Terapia Médica es un beneficio gratuito del programa de CCS que no requiere elegibilidad financiera. Los servicios de terapia ocupacional y fisioterapia recetados por la conferencia de Terapia Médica también son gratuitos. Para Rayos-X, aparatos, equipo médico durables, servicios médicos o cirugías recomendadas, CCS requiere elegibilidad financiera para ser autorizados por el programa..

Para que su niño/a se sienta más cómodo durante el exámen medico, podría usar un pantaloncito corto o traje de baño debajo de su ropa, en caso que sea necesario quitarle la ropa. Por favor, en el día de clínica traiga con usted aparatos, férulas, zapatos ortopédicos, muletas o caminadores que su niño/a esté usando hasta ese momento.

Sus preguntas o preocupaciones son importantes para nuestro programa. Por favor, anote, en el lugar indicado abajo, cualquier pregunta o preocupaciones que tenga sobre su niño/a y tráigalas con usted el día de la clínica.

1. _____
2. _____
3. _____

Ud. puede y tiene la libertad de invitar a la clínica a su coordinador/a de Early Start (Comienzos Tempranos), personal del Centro de Servicios Regional de los Tres Condados, maestro/a de su niño/a. **Como resultado de esta Conferencia/Clinica de Terapia Médica los planes de tratamiento de terapia ocupacional y/o fisioterapia pueden ser modificados.**

Favor de llamar al 967-7758 a más tardar _____ para confirmar su asistencia a esta cita. Las citas son limitadas y le pedimos haga todo lo possible para asistir. El pedido de una nueva cita tendrá como resultado una demora en los servicios. Muchas gracias.

Sinceramente,

Valerie L. Vigil
Asistente de Oficina

**Physical/ Occupational Therapy Initial/ Progress Assessment
CCS MEDICAL THERAPY PLAN/PRESCRIPTION**

Child's Name:	DOB:	Chronological Age:	CCS#:	Referral Date:
Primary Care Physician:		MD Directing Therapy Services:		MTP Medically Eligible Condition:
Therapist:	School:	Treatment Diagnosis:		Date of Report:

I. Current Functional Status:(DEpendent, MAXimum assist, MODerate assist, MINimum assist, Contact Guard Assist (CGA), Stand By Assist (SBA), SUPervised, Modified Independent (Mod I), Independent) * = with adaptive equipment N/T=Not Tested # = Age Appropriate

Ambulation:	Bathing:	Community Skills:	Dressing:
Feeding:	Home Skills:	Mobility:	Play/Vocational:
Prewriting:	Toileting:	Transfers:	Other:

II. Benefits of Previous Therapy Services:

III. Short Term Functional Goal(s):

- A. (Goal)**
1. (Objective)
 2. (Objective)
 3. (Objective)
- B.**
1. (Objective)
 2. (Objective)
 3. (Objective)

IV. Recommended Therapy Services: (Subject to staff availability)

	Frequency	Duration	Location
A. Monitor/Periodic Checks: <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> 60 min sessions			
B. Direct Treatment: <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> 60 min sessions			MTU
C. Treatment Plan:			
<input type="checkbox"/> Gait Training	<input type="checkbox"/> Functional Activities	<input type="checkbox"/> Splinting	<input type="checkbox"/> Modalities
<input type="checkbox"/> Transfer Training	<input type="checkbox"/> of Daily Living(ADL)	<input type="checkbox"/> Oral Motor	<input type="checkbox"/> Community Skills
<input type="checkbox"/> Functional Mobility	<input type="checkbox"/> Therapeutic Exercise	<input type="checkbox"/> Home Program	<input type="checkbox"/> Home Skills
			<input type="checkbox"/> School Program
			<input type="checkbox"/> Consultation
			<input type="checkbox"/> Evaluation
			<input type="checkbox"/> Other
D. <input type="checkbox"/> No therapy indicated. Follow in MTU Conference/Clinic only <input type="checkbox"/> Close MTP Services			

V. Change from previous Plan/Prescription: yes no **VI. Proposed date of Initiation of Therapy Plan:** _____
VII. Proposed date of medical (re)evaluation: 6 months from date of report; 1 year from date of report; Other

Therapist Name, PT	Date	(805) Telephone #
--------------------	------	-------------------

I have participated in the development of this treatment plan for my child and consent to its implementation. I also agree to periodic reassessment of my child's needs.

Parent Signature	Date
------------------	------

Physician: Please review the above treatment plan and indicate any needed changes or additions and sign below.

Comments/Changes or Additions to Plan: _____

Precautions: _____ Rehab Potential: ___ Good ___ Fair ___ Limited

I agree with the above therapy treatment plan with noted changes or additions. My signature will act as prescription for treatment as designated above, as well as for periodic reassessment.

, MD	License Number	Date
------	----------------	------

*Physician's and therapist's signature are required in order for CCS MTP services to be provided and to signify an approved therapy plan.
 Please return signed Plan/Prescription to: MTU ADDRESS

Distribution: PCP: _____ MTU: _____ CCS: _____ Parent/ Guardian: _____ TCRC: _____ LEA: _____ RR8 (07/01)



Takashi M. Wada, MD, MPH Director/Health Officer
Anne M. Fearon Deputy Director
Suzanne Jacobson, CPA Chief Financial Officer
Michele Micklewicz, MPH Deputy Director
Elizabeth Snyder, MHA Deputy Director
Peter Hasler, MD Medical Director

LEA NOTIFICATION OF MEDICAL THERAPY PROGRAM STATUS

Date:

To: (LEA)

Re: _____ Birthdate: _____

CCS has received a referral from this child's Local Education Agency (LEA) for CCS Medical Therapy Program (MTP) services. This notice is to inform the LEA that this child is medically eligible for the MTP and the following has been completed thus far:

- () The Therapy Assessment Plan has been signed by parent/caregiver and LEA notified.
- () The MTP Consent for Participation in the CCS Medical Therapy Program (Consent for Treatment) has been signed by parent/caregiver.
- () Therapy assessment report and proposed therapy plan have been reviewed with parent/caregiver.
- () Notice of Medical Therapy Conference (MTC) has been sent to parent/caregiver and to the LEA *or* the child will be seen by a private CCS panel physician.
- () Child has been examined by the physician.
- () Therapy Plan/Prescription has been signed by the physician and approved by the MTC team and a copy has been sent to the parent/caregiver and LEA.

SUPERVISING THERAPIST

DATE

MTU

cc: parent/caregiver

RR9



Takashi M. Wada, MD, MPH *Director/Health Officer*
Anne M. Fearon *Deputy Director*
Suzanne Jacobson, CPA *Chief Financial Officer*
Michele Micklewicz, MPH *Deputy Director*
Elizabeth Snyder, MHA *Deputy Director*
Peter Hasler, MD *Medical Director*

LEA NOTIFICATION OF POSSIBLE DELAY IN DETERMINING MEDICALLY NECESSARY THERAPY SERVICES

Date:

To: (LEA)

Re: _____

Birthdate: _____

There may be a delay in responding to your referral for CCS Medical Therapy Program (MTP) services because of one or more of the following:

- () The parent/caregiver has not made or kept the appointment for diagnostic evaluation.
- () No medical reports have been received from the authorized physician in order to review and determine medical eligibility.
- () Parent/caregiver has not signed the Therapy Assessment Plan.
- () Parent/caregiver has not signed the Consent for Participation in the CCS Medical Therapy Program (Consent for Treatment).
- () Parent/caregiver has not made or kept appointment for Therapy Assessment.
- () Parent/caregiver has not kept appointment for Medical Therapy Conference.
- () OTHER _____

SUPERVISING THERAPIST

DATE

MTU

cc: parent/caregiver

RR10



Rea Goumas, MD
Medical Director

Ana Stenersen
Program Director

**MEDICAL THERAPY PROGRAM
SECOND EXPERT OPINION PROCESS**

California Children Services (CCS) provides a formal structure for disagreeing with a decision made by the CCS Medical Therapy Conference/Clinic Team. If you disagree with the medical therapy treatment plan developed by the Clinic Team, you can ask for a second expert opinion. The CCS program will provide you with the names of three physicians with experience in the treatment of children with physical disabilities and will pay for an evaluation and second opinion from your choice of the three. The CCS Due Process system delegates the final decision to the expert consultant with no subsequent recourse to further appeal by either party.

If you wish to use this process, the following are the necessary steps to take:

1. If, after reviewing the medical therapy treatment plan with the Medical Therapy Conference/Clinic physician(s), you continue to disagree with their opinion, submit a **written request for a second expert opinion** within five (5) calendar days of the clinic review to:

Rea Goumas, MD
Medical Director
Santa Barbara County CCS
345 Camino del Remedio
Santa Barbara, CA 93110

Your request should include the MTU Conference/Clinic Team decision with which you disagree; the action you want taken; any supportive information or documentation; and whether you wish to have current therapy services continued during the resolution process.

2. Within five (5) calendar days from receipt of your request, CCS will mail you a list of three expert physicians. You may choose one and must inform Dr. Goumas of your choice within 20 calendar days. CCS will authorize and pay for an appointment with the expert physician for a physical evaluation and a second opinion regarding needed therapy services.

The expert physician's findings will be a binding opinion on the type, frequency, and duration of therapy services to be provided through the Medical Therapy Program.

If you would like more information regarding this process, please contact Ana Stenersen, Program Director and/or the Medical Therapy Program Coordinator at (805) 681- 5362



Rea Goumas, MD
Medical Director
Ana Stenersen
Program Director

**PROGRAMA DE TERAPIA MÉDICA
PROCESO DE UNA SEGUNDA OPINION DE UN EXPERTO**

El programa de servicios para niños en California (CCS) ofrece un proceso de estructura formal en el caso de no estar de acuerdo con alguna decisión tomada por el equipo de Conferencia Médica de Terapia. Si usted no está de acuerdo con el plan de tratamiento de terapia desarrollado por el equipo de clínica medica, usted puede pedir una segunda opinión de un experto médico. El programa de C.C.S. le proveerá con una lista de nombres de tres doctores con experiencia en tratamiento de niños con incapacidades físicas. También pagará por la evaluación del doctor de su elección. El proceso debido legal del CCS delega la decisión final del experto consultante con ningún subsiguiente recurso de futuras apelaciones por cualquiera de las dos partes.

Si usted elije usar este proceso, necesitará seguir los siguientes pasos:

1. Si, despues de discutir/revisar el Plan de Terapia Médico con el doctor (es) de Conferencia de la Clínica Médica, usted continúa en desacuerdo con la opinión provista, **tiene que entregar una petición por escrito para obtener una segunda opinión de un experto médico**, dentro de un período de (5) días despues de la Conferencia de Clínica Médica a:

Rea Goumas, MD
Medical Director
Santa Barbara Co. CCS
345 Camino Del Remedio, Bldg. 4
Santa Barbara, Ca. 93110

Su petición deberá incluir la decisión tomada por el equipo de Conferencia Clínica Médica con el cual usted no esta de acuerdo; la acción que usted le gustaría tomar; alguna información o documentación que le apoye; y si desea o no que continúen los servicios de terapia actuales durante el proceso de resolución.

2. Dentro de los (5) días calendarios despues de haber recibido su petición, C.C.S. le enviará por correo una lista con los nombres de 3 doctores expertos. Usted tiene que elegir uno e informarle a la Doctor Goumas de su elección, no mas tarde de 20 días calendarios. CCS autorizará y pagará por la cita con el experto médico para una evaluación física y una segunda opinión acerca de servicios de terapia necesarios.

Los hallazgos del experto médico serán una opinion definitiva, en cuanto al tipo de frecuencia y duración de los servicios de terapia que serán provistos por el programa de terapia.

Si desea más información acerca de este proceso, por favor de llamar al Coordinador de los servicios de Terapia y Clínica Médica al (805) 681-5360.