

# A Guide to Transition Services for Youth with Special Health Care Needs



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### **A Guide to Transition Services for Youth with Special Health Care Needs**

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Note to users:

Descriptions of services, the policies and procedures for the various state agencies, not-for-profit organizations and advocacy groups were taken from previously published, public documents. The information provided in this Guide reflects the best efforts of those involved to accurately and clearly summarize information from those original sources.



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## What are "Special Health Care Needs"?

Every child is special and all children deserve attention to their health care needs. Some children have needs that are greater than most. Special health care needs can be:

- Physical, emotional or behavioral
- Conditions that last a lifetime or end with treatment
- Easy to see or not seen at all

For individuals with special health care needs, consideration of medical issues and matters of health are critical components of transition planning.

## What does "Transition" involve?

Transition planning begins long before a young person approaches the point of leaving home. In the broadest sense, all the skills we develop throughout childhood and adolescence are preparing us for independent living as adults.

As young people approach the end of their public school experience, families typically focus on:

- post-secondary education and training opportunities
- career and vocational options
- communication and domestic skills required for independent living
- opportunities for social interaction, recreation and leisure

For children with special health care needs, medical issues and health care concerns are a significant component intertwined with all domains of independent living.

## What does "Medical Transition" mean?

"Medical Transition" might more accurately be called "Health Care Transition" because it is often necessary to seek different providers of adult care for a variety of services:

- Oral health or dental care
- Mental health or behavioral specialties (Psychologists, Psychiatrists)
- Therapy or consultation (Speech/Language Clinicians, Physical Therapists, Nutrition Consultants)
- Preventive care, routine check-ups, emergency care, specialty care

Health Care Transition, therefore, is the process of moving from pediatric, child-centered care to an adult-centered health care system. This process involves:

- Often, shifting care to new, adult-centered primary care physicians and specialists
- To the extent possible, shifting responsibilities from parents to the young adult
- Maximizing independence and providing support systems as needed
- Systematic planning from an early age

## What is meant by the term "Medical Home"?

A "Medical Home" is not a place, but rather an approach to providing health care services. It represents a partnership between your primary care physician, other health care professionals and your family.

A Medical Home is defined as a system where health care services are accessible, family centered, continuous, comprehensive, coordinated, compassionate and culturally responsive.

### **The Colorado Medical Home Initiative provides the following description:**

- **A Medical Home is a concept of *quality* health care**
- **It is a team approach to coordinating health care services**
- **A Medical Home promotes a partnership between families and providers**
- **A Medical Home encompasses medical, mental and oral health care**
- **It is accomplished when families feel included and valued; when care and treatment options are mutually discussed and collaboratively decided**

Family members are typically the principal caregivers for children with special health care needs, the principal sources of emotional support for their children and the individuals most familiar with their treatment history, strengths and needs. Family members should expect and advocate for the support of professionals as they participate as partners in the decisions made surrounding care coordination and treatment options.

Beyond the direct medical and health needs, there are financial concerns, educational and social issues that factor in as components of a system of comprehensive care. The Medical Home concept acknowledges this. Again, you should expect and advocate that health care professionals stand ready to share and receive information relevant to all domains that are important to the wellness of your child.

The concepts of a Medical Home should provide guidance in the transition process.

## How does the "adult system" differ from children's systems of care?

For children, the school system provides and helps to coordinate many services, accommodations and modifications for students with developmental and physical disabilities and special health care concerns. When education is impacted, accommodations are mandated and waiting lists should not exist. Adult systems often lack mandates, eligibility criterion are sometimes more restrictive and waiting lists are common. As children "graduate" to adult systems of care, it is critical to understand what services are available and to know how those services can be accessed.

## Why is it necessary to seek adult care providers? Why can't my pediatrician continue to serve as my child's primary care physician?

In some cases, there may be no necessity or opportunity to seek a different doctor. In other cases, the shift may be very advantageous or absolutely required. What factors come into play?

While most of us understand many aspects of specialization in medicine – cardiology (heart), otolaryngology (ear, nose and throat), neurology (nervous system) – when it comes to a more general practitioner such as our primary care physician, many people wonder: What is the difference between treating children and adults? Why would an individual leave the pediatric practice that he or she is familiar and comfortable with to seek an adult care provider?

In truth, pediatrics (childhood medicine) is a medical specialty. Knowing about growth and development as children move from infancy through childhood to adolescence requires specialized study. There are conditions and disease processes that are unique to children. Pediatricians, for example, have more training and experience with genetic and congenital conditions.

By the same token, physicians whose practice focuses only on adults (these general practitioners are often called internists) are more aware and familiar with conditions that are not seen in childhood. One obvious example would relate to sexual maturity and reproductive issues.

Sometimes a shift in providers may be required because of insurance limitations or preferred because of the scope of a doctor's certification. Sometimes the clinic or hospital where a physician works sets limits. Often programs discontinue services at a specific age (18 for example) or the nature or level of service is different.

Many children, however, are cared for by a Family Physician who has expertise in the medical care of both children and adults. Continuation of care under such an individual might, in fact, be the ideal circumstance. In such cases, there should be time set aside in late adolescence or early adulthood to acknowledge transition and discuss issues specific to this milestone.

Your own physician can help you understand your options and the factors specific to both his or her circumstance and the specific needs of your child and family as you and your child explore health care transition.

## Which students need transition planning and when?

A planning process for life after graduation - identifying dreams, goals, instructional needs and supports - is beneficial for all students regardless of any disability or special health care need. Generally, it is recommended that transition planning begin no later than eighth grade. Many school systems begin the process of transition planning in elementary school.

For some individuals with special health care needs, a long-term plan, starting at a much earlier age, may be required.

## What kind of transition questions should we be asking?

Clearly, your specific concerns will lead to the critical questions that must be answered. The following list (from the Colorado Department of Education [Transition Toolkit](#)) provides a general guide:

- Where is the student going vocationally (competitive or supported employment, volunteer work)?
- Will the student need post-secondary education or training?
- Where will the student live and what support will be needed?
- What will the student's transportation needs be?
- How will the student maintain his or her social life?
- What type of leisure activities will the student participate in?
- How will the needs be met for medical/dental/mental health care, including health insurance?
- What community agencies can help and how will they be accessed?

With specific regard to health care transition, the following should be considered:

- Are there issues of guardianship to be explored?
- What are the thoughts of your current health care providers regarding continuation of services?
- If resources through a Community Centered Board (CCB) are likely, will an updated cognitive and adaptive assessment be required?

## How does the Colorado Department of Education (CDE) view the schools' role in the transition process?

For student receiving special education services, the following three concepts define the essential elements of transition planning:

- Coach every student, along with his or her family, to think about goals after high school and to develop a long-range plan that will get them there
- Design high school experiences to ensure that the student gains the skills needed to reach his or her desired post-school goals
- Identify and link students and families to any needed post-school services, supports or programs before the student exits the school system

## How can the public schools help address our specific health care concerns?

For students who do not receive special education services, but may require special consideration for transition planning, schools are prepared to provide counseling and assistance. For students receiving special education services, transition planning is a required element of their educational program.

### ▪ **Special Education and the Individualized Education Program (IEP) Process**

Most people think of developmental disabilities and intellectual impairments when they think of special education services in the public schools. In truth, schools provide special planning, modifications and accommodations for students with varying mental or physical conditions to insure that all students receive a reasonable and appropriate general education. Students with significant health care concerns which impact their ability to participate in the general education process may be eligible, under federal law, to receive special education services. These services will include transition planning.

### ▪ **504 Plans**

Students who have significant and chronic health care concerns, but who do not meet the eligibility requirements to receive special education services, may be entitled to receive accommodations and a personalized action plan through a general education process commonly referred to as a "504 Plan".

Whether or not an IEP or 504 Plan is in place, there are school personnel who are knowledgeable about transition issues and are able to provide help. Assistance with transition planning, apart from any special program, should be available to you through the public schools.

### ▪ **School to Work Alliance Program – SWAP**

SWAP is an optional, collaboratively funded program between school districts and the Department of Vocational Rehabilitation (DVR). The program serves youth that have mild to moderate needs in employment, meet eligibility requirements for DVR services and are likely to require short-term services to become successfully employed. To find out if SWAP is available in your area, talk to your special education teacher or your local DVR office.

### ▪ **School Nurses**

School districts employ or contract the services of registered nurses. The availability and specific duties of a school nurse may vary from district to district and school to school, but the following chart provides an overview of how the Colorado Department of Education views the delivery of wellness and health care services. The school nurse will be a vital contact in helping you understand how the school will best be able to serve the needs of your child and explain specifically what the "levels of support" mean to you and your family (see the chart that follows). A school nurse might also be involved in the creation of an Individualized Health Care Plan (IHP). (The IHP and the specific role of the school nurse are described on page 7.)

(The Colorado Department of Education website provides detailed information regarding essential school health services and the role and responsibility of a school nurse: [www.cde.state.co.us](http://www.cde.state.co.us) See: School Nursing and Health Services.)

▪ **SWAAAC Teams**

SWAAC (the original acronym) was initiated by the Colorado Department of Education in 1993 in response to increasing needs to serve students who use or need devices for augmentative or alternative communication (AAC). Later, in response to the reauthorization of the federal IDEA legislation, the scope of focus was expanded to include all forms of assistive technology – hence the addition of a third "A" to the acronym. School SWAAAC Teams provide expert, multi-disciplinary assistive technology services to students with disabilities. These teams partner with classroom teachers, special educators and school staff to enable students with disabilities to participate in and have full access to all educational opportunities.

Specifically regarding *health care needs*, what services can we expect from the school system here in Colorado?

The following chart represents Colorado's school-wide system of support for student success. There is a continuum of services and supports designed to meet different levels of need.

| Level of Support                                                                                                                                                                                                 | Support Examples                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Intensive/Individualized Level (1-5%)</b><br><br>Interactions based on comprehensive evaluation are provided to students with intensive needs.                                                                | <ul style="list-style-type: none"> <li>▪ Individualized health care plans for students requiring health-related accommodations and modifications</li> <li>▪ Delegation, training and supervision of unlicensed health staff</li> <li>▪ Provision of health components for special education, Child Find and 504 plans</li> </ul>                                                                                          |
| <b>Targeted Level ( 5-10%)</b><br><br>Provided to students identified at-risk or who fail to make adequate progress in general education.                                                                        | <ul style="list-style-type: none"> <li>▪ Early detection of students identified to be potentially at-risk</li> <li>▪ Referral for appropriate early intervention</li> <li>▪ Participation on school health advisory teams to address risk behaviors</li> <li>▪ Provision of health-related professional development for school staff</li> </ul>                                                                           |
| <b>Universal Level (80-90%)</b><br><br>Provided to ALL students; research-based, high quality, general education using on-going universal screening, progress monitoring, and assessments to design instruction. | <ul style="list-style-type: none"> <li>▪ Prevention of illness and injury</li> <li>▪ Promotion of healthy behaviors</li> <li>▪ Assurance of the quality &amp; accessibility of health services</li> <li>▪ Protection against environmental hazards</li> <li>▪ Provision of assessment and evaluation of all students</li> <li>▪ Participation in the development and presentation of health education programs</li> </ul> |

## What are "Care Plans" and "Portable Medical Summaries"?

These are generic terms for documents that record important information about your child. There are many variations. Templates or blank forms are available through many national websites. The Healthy and Ready to Work website offers links to several examples: [www.hrtw.org](http://www.hrtw.org) (Tools & Checklists).

A **Care Plan** is basically an action plan. It is in many ways similar to an IEP or 504 Plan that you may be familiar with through the school system. Often, a Health Care Plan is an important component of either of those two school documents. Quite simply, a Health Care Plan would describe what needs to be done and who will be responsible for doing it. (A following section describes how a school nurse might be involved in developing such a plan.)

A **Portable Medical Summary** is a document that organizes medical information and related facts in a concise way. Such a summary would provide a history, but with an emphasis on current management strategies and medical information. Many include information about functional independence and communication strategies that may be immediately helpful to a new physician or health care specialist. Your current physician or a health professional such as a school or public health nurse may be able to offer help in drafting such a summary. The "It's Time to Transition" workbook, available through the HCP website, provides an excellent example of such a tool. See: [www.hcpcolorado.org](http://www.hcpcolorado.org)

## School Nurses and Individualized Health Care Plans \* (reference provided on following page)

### What is an IHP?

An Individualized Health Care Plan (IHP) is designed to meet the needs of a student with chronic health problems. The IHP is designed to manage the health care concerns within the school setting – to ensure that problems are identified and addressed that may create a barrier to educational progress, safety or well-being.

Standardized IHPs are available for the most frequent chronic health problems that occur in school-aged children, but individualization is essential in order to meet the unique needs of each student.

### Who creates an IHP?

Ideally, a professional school nurse should be responsible for writing the IHP in collaboration with the student, family, school staff and health care providers.

### What is the rationale for an IHP.... how can it be useful?

The IHP can assist in many areas:

- Professional school nurses utilize IHPs to communicate nursing care needs to administrators, staff, students and parents.
- The IHP will create a safer process for delegation of nursing care, supporting continuity of care.
- The IHP can serve as the health plan component of a 504 plan.
- For students qualifying for special education, the IHP can be incorporated into the Individualized Education Program (IEP) when the health care issues are related to the educational needs of the student.
- The IHP will serve as legal protection by showing that proper plans and safeguards, such as an Emergency Care Plan, were in place.

### **What guidelines are suggested to determine the need for an IHP?**

Beyond the general description provided above, the National Association of School Nurses provides the following guidelines:

Identifying students who...

- Are medically fragile with multiple needs
- Require lengthy health care or multiple health care contacts with the nurse or unlicensed assistive school personnel during the school day
- Have health needs that are addressed on a daily basis
- Have health needs addressed as part of their IEP or 504 plan

Focusing on health issues that affect...

- Safety
- The student's ability to learn
- Issues that the student, teacher and/or parents perceive as priorities

\* The information provided here was taken from the *National Association of School Nurses (NASN)* website. The entire **Position Statement** regarding **Individualized Health Care Plans** can be accessed at: [www.nasn.org](http://www.nasn.org)

### **What are the planning needs for youth with behavioral or emotional needs?**

For youth with emotional or behavioral difficulties, and for their families, the transition to adulthood can be especially daunting and sometimes overwhelming. For youth, families and service providers, there are additional tasks: assuring continuing and effective services and benefits, understanding medications and their side effects, locating appropriate housing, locating financial help and securing ongoing support. Transition may mean re-entry to the community from group, residential or institutional care. It may mean obtaining residential services beyond age 18. Transition may also mean coping with the awareness and challenge of an emerging, chronic mental health condition.

School personnel and their social service partners know the systems, diagnoses and funding streams in place for *children*, but they may be unfamiliar with the *adult* system that can have a different set of diagnostic categories and funding streams. Successful transition planning must outline, and also help implement, the strategies that will provide the necessary information and connections to assure that appropriate mental health supports and services will be in place.

An excellent resource is a book entitled *Transition to Adulthood: A Resource for Assisting Young People with Emotional or Behavioral Difficulties*\*. The authors, Hewitt Clark and Maryann Davis, offer advice and strategies applicable to any youth in transition. Two recommendations of particular importance to youth with emotional or behavioral issues emphasize that 1) good planning transcends age barriers typical of youth versus adult services and 2) the planning be an individualized, person-centered process driven by the young person's cultural and familial values, interests and strengths. A developmentally appropriate, strengths-based approach increases youth motivation and creates a meaningful transition process.

\**Transition to Adulthood: A Resource for Assisting Young People with Emotional or Behavioral Difficulties*, Clark, Hewitt B. and Davis, Maryann. Brookes Publishing Co., Baltimore, MD, 2000.

## What is a "Behavior Intervention Plan"?

Students served under Section 504 of the Americans with Disabilities Act (ADA) and the Individuals with Disabilities Education Act (IDEA) are granted some procedural safeguards regarding discipline and behavior management. If problematic behaviors are found to be a result or manifestation of a student's disability, review of the current program and consideration of appropriate changes should be made. This review should include a functional assessment of the student's behavior. The information obtained from that process might lead to the development of a Behavior Intervention Plan. The purpose of this plan is to spell out what behaviors are being targeted for change and how that change will be managed.

## What should be included in a "Behavior Intervention Plan"?

Some elements of the Behavior Intervention Plan are required by IDEA. Other elements are offered as suggestions for good planning.

### Required Elements

- A description of previously tried interventions – how well they did or didn't work
- A definition or description of the behavior being targeted
- A description of the intervention
  - Who will be involved
  - The specific procedures to be followed
  - How data will be collected
- A measurable description of the behavioral changes you expect to see
- A description of how the success of the interventions will be measured
- A schedule for when/how often the plan will be reviewed
- A description of how information will be shared between home and school
- A description of how the student's behavior will be handled should it reach crisis proportions (Crisis Plan)

### Recommended Elements

- A list of the student's abilities and strengths
- Important information about the student that could impact the plan
- A statement describing the function (purpose) of the targeted behavior (from the Functional Assessment)
- A description of the behavior that will replace the inappropriate behavior (often called the "replacement behavior")

## How can a student prepare to more independently manage health care concerns?

There are many guides and checklists that have been prepared to help young people begin the transition process. The following series of three checklists is taken from one such guide entitled Envisioning My Future - A Young Person's Guide to Health Care Transition prepared by Children's Medical Services, Florida Department of Health.

For each age group, the checklist of health related activities helps identify critical issues and helps a young person see where he or she is on the road to a successful transition to greater independence.

## New Responsibilities, Practicing Independence and Taking Charge

Check the items that are true for you.

| <b>New Responsibilities<br/>Check List (ages 12-14)</b>                                      | <b>Practicing Independence<br/>Check List (ages 15-17)</b>                                           | <b>Taking Charge<br/>Check list (age 18 and up)</b>                                                                                                               |
|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| I can describe how my disability or health condition affects my life.                        | I keep a personal health notebook or medical journal.                                                | I can tell someone the effects that getting older may have on my disability or health condition.                                                                  |
| I can name my medications (using their proper names), and the amount and time I take them.   | I record my medications when my supply is low and call my doctor when I need a new prescription.     | I can tell someone about medications that I should not take because they might interact with the medications I take.                                              |
| I answer at least one question during a health care visit.                                   | I answer many of the questions during a health care visit.                                           | I am alone with the doctor(s) or choose who is with me during health care visits.                                                                                 |
| I have talked with my doctors or nurses about going to different doctors when I am an adult  | I spend most of the time alone with the doctor(s) during health care visits.                         | I answer all the questions during a health care visit.                                                                                                            |
| I manage my regular medical tasks at school.                                                 | I tell my doctors I understand and agree with the medicines and treatments they suggest.             | I have identified adult doctors and facilities that I will go to when I leave my current doctors and facilities.                                                  |
| I can call my primary care doctor's or specialist's office to make or change an appointment. | I know if my doctors do not take care of patients who are older than a certain age (for example, 21) | I manage all of my regular medical tasks outside the home (school, work).                                                                                         |
|                                                                                              | I regularly do chores at home.                                                                       | I can tell someone what new legal rights and responsibilities I gained when I turned 18 years old. (sign medical forms / make medical decisions by myself)        |
|                                                                                              | I can tell someone the difference between a primary care doctor and a specialist.                    | I can tell someone how long I can be covered under my parent's health insurance plan and what I need to do to maintain coverage. (such as be a full-time student) |

### Envisioning My Future – A Young Person's Guide to Health Care Transition Children's Medical Services, Florida Department of Health \*

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## Where can I find information about Health Insurance, especially Medicaid?

Many of the national websites offer a good overview of insurance issues and public assistance. The Healthy and Ready to Work (HRTW) site is very comprehensive: [www.hrtw.org](http://www.hrtw.org) GovBenefits.gov offers tools to help individuals determine which programs might provide them assistance or benefits. This site gives an explanation of programs with a link that offers Colorado-specific information about eligibility: [www.govbenefits.gov](http://www.govbenefits.gov) The United States Department of Human Services, Agency for Health Care Research and Quality website also has a "Consumer and Patients" section that may prove helpful: [www.ahrq.gov](http://www.ahrq.gov)

It is important to understand that Medicaid is a state administered program. Colorado sets its own guidelines for Medicaid in accordance with federal rules and regulations. To find general information about health care in Colorado and to see such topics as "Eligibility for Medicaid" and "Frequently Asked Questions" go to the Department of Health Care Policy and Financing, Office of Medicaid Assistance website: [www.chcpf.state.co.us](http://www.chcpf.state.co.us)

## What are some activities parents can begin to do in preparation for the transition process?

Even before transition issues become part of a formal IEP or general education program in school, parents can begin the following activities:

- Investigate what services and programs exist in your child's school
- If an IEP or 504 Plan is in place, participate fully in the process
  - Start asking questions early
  - Be certain your child is present and actively participating in all meetings
  - Advocate for expanded services and a positive transition curriculum
  - Maintain involvement and communication between meetings
- Together with your child, gather and organize medical and health related records
- Seek individuals or families with circumstances similar to your own who have been through the transition process and can offer advise and support
- Discuss the relationship between health concerns and independence
- Encourage and help develop greater independence in your child's ability to
  - Describe clearly his or her medical condition and treatment needs
  - Participate more actively and directly in doctor's appointments
  - Recognize signs and symptoms that require medical attention
  - Be an effective self-advocate
  - Manage self-care, equipment maintenance and medications
  - Make wise decisions
  - Access services and seek help (at home, at school, in the community)
  - Keep record of and organize his or her own medical history

## What are the school's responsibilities in linking or helping us connect with adult agencies?

For student receiving special education services, the following are expectations regarding transition planning and the IEP process:

- Schools must invite a representative of any other agency that is likely to be responsible for providing (or paying for) transition services to any meeting where goals and transition services are being planned
- If an agency representative does not attend the scheduled meeting, the school must take other steps to obtain their participation in the planning of any transition services
- Schools must assist the student and family to make connections to appropriate adult agencies prior to the student exiting the school to assure there are no gaps in services provided
- Schools must inform students and families about community resources and agencies, and facilitate appropriate linkages

## What services do community agencies provide?

- **Colorado Division of Vocational Rehabilitation (DVR)** [www.cdhs.state.co.us/dvr/](http://www.cdhs.state.co.us/dvr/)  
Often called "Voc Rehab" or "VR" programs, Vocational Rehabilitation Agencies assist persons with cognitive, physical or emotional disabilities in their efforts to seek and maintain employment. This state agency assists individuals to enter, re-enter or maintain employment and increase skills for independent living. DVR Counselors can be helpful in linking clients with other agencies for support services that will enhance their ability to work.
- **Colorado Department of Human Services (CDHS)** [www.cdhs.state.co.us](http://www.cdhs.state.co.us)  
CDHS oversees the state's 64 county departments of social/human services, the state's public mental health system, Colorado's system of services for people with developmental disabilities, the state's juvenile corrections system and all state and veterans' nursing homes. For information about traditional social services, including programs such as public assistance and child welfare services, contact your local county department of social/human services.
- **Division for Developmental Disabilities,**  
**Colorado Department of Human Services** [www.cdhs.state.co.us/ddd/CCB\\_Main.htm](http://www.cdhs.state.co.us/ddd/CCB_Main.htm)
- **Statewide Community Centered Boards (CCBs)**  
In 1963, Colorado statute authorized CCBs to be responsible for community services for both children and adults with developmental disabilities. Currently there are 20 Community Centered Boards who serve approximately 11,000 individuals and families across the state. Local CCBs are often known by titles that do not incorporate "CCB" into their title. For example:
  - Arapahoe County/Douglas County/Aurora = Developmental Pathways
  - Denver County = Denver Options, Inc.
  - El Paso County/Park County/Teller County/Colorado Springs = Resource Exchange
  - Boulder/Broomfield = Imagine!
  - Larimer County = Foothills Gateway
  - Pueblo County = Colorado Bluesky Enterprises, Inc.
  - Weld County = Envision

- **Colorado Department of Public Health and Environment**  
**Health Care Program for Children with Special Needs (HCP)** [www.hcpcolorado.org](http://www.hcpcolorado.org)  
HCP is a statewide program that provides information, referral to services and support to families. HCP professionals are able to help families find:
  - o Medical care, health and community services
  - o Financial assistance
  - o Family support groups
  - o Answers to their questions
  
- **Colorado Department of Labor and Employment – Workforce Centers** [www.coworkforce.com](http://www.coworkforce.com)  
Workforce centers are located throughout the state and offer job referrals, career guidance and counseling. The Centers work closely with the Division of Vocational Rehabilitation to obtain more intensive services that may be needed by clients with disabilities or special health care needs.
  
- **Colorado Community College System** [www.cccs.edu](http://www.cccs.edu)  
The Colorado Community College System focuses on secondary and post-secondary career and technical education. The statewide system offers services and supports to assist persons with disabilities select and succeed in career and technical assistance training programs. Each community college and vocational school has a Special Populations Coordinator or Disabilities Services Coordinator on staff.
  
- **Social Security Administration** [www.socialsecurity.gov](http://www.socialsecurity.gov)  
The Social Security Administration is responsible for federally funded programs that assist individuals who are unable to do substantial work and have a significant mental or physical disability. These programs include:
  - o Social Security Disability Insurance (SSDI)
  - o Supplemental Security Income (SSI)
  - o Plans to Achieve Self-Support (PASS)
  - o Medicaid and Medicare
  
- **Assistive Technology Partners** [www.AssistiveTechnologyPartners.org](http://www.AssistiveTechnologyPartners.org)  
Assistive Technology Partners (ATP) is a resource center for information and training regarding tools and strategies available to assist individuals with physical or sensory limitations. ATP can provide information regarding wheelchair use, augmentative and alternative communication systems, learning tools, computer adaptations and software, technologies for individuals with vision impairments, adaptations in home and work environments and many more topics. ATP offers monthly "Open Labs" at their Denver location. There is a Western Slope Technical Assistance Center located in Grand Junction and one available in the Colorado Springs/Pueblo area.

- **Independent Living Centers**     [www.uchsc.edu/atp/library/fastfacts/htm](http://www.uchsc.edu/atp/library/fastfacts/htm)  
(Statewide Independent Living Council)

Independent Living Centers typically offer information and referral services plus training opportunities that focus on developing self-sufficiency within the community.

- **Family Voices of Colorado**     [www.familyvoicesco.org](http://www.familyvoicesco.org)

Family Voices of Colorado is a chapter of the national, grassroots organization composed of families and friends who care for and about children with special health care needs. Family leaders from around the nation organized Family Voices in December 1992. The primary goal of the organization is to ensure that children's health is addressed amidst change in public and private health care systems. In Colorado, Family Voices provides training, advocacy support and works to affect policy and system change.

- **PEAK Parent Center**     [www.peakparent.org](http://www.peakparent.org)

PEAK Parent Center is a non-profit organization funded by the U.S. Department of Education as Colorado's Parent Training and Information Center (PTI). PEAK provides information, training and technical assistance to equip parents with strategies to advocate effectively for their children with disabilities so that they can participate as full members of their schools and communities.

From the website provided above, you can locate and contact the CCB designated to serve your county to learn more about Early Intervention, Family Support and Adult Services.

- **The Arc of Colorado**     [www.thearcofco.org](http://www.thearcofco.org)

The Arc of Colorado is a private, not-for-profit organization that advocates for people with developmental disabilities to develop competencies and to make choices; to have good relationships with family members and friends, have dignity and respect, and to be full participants in their communities.

Arc Units are located around metropolitan Denver and in Boulder, Pueblo, Mesa County and Weld County.

## How can I contact any of these agencies listed above?

Additional website addresses and telephone numbers are provided as a supplement to this handbook. The "211" telephone information referral service can also provide current contact information for these and other related agencies.

The Colorado Department of Education (CDE) offers a **Transition Toolkit** entitled *Chart a Course for the Future* that provides more extensive information on the state agencies described above, along with other resources and tools. Any portion of the **Toolkit** can be downloaded at no cost from the Colorado Department of Education website: [www.cde.state.co.us](http://www.cde.state.co.us)

**Health Care Program for Children with Special Needs (HCP)**  
**Prevention Services Division ~ Colorado Department of Public Health and Environment**

**303 692-2370 or 1 800 886-7689 and Fax: 303 753-9249**  
**[www.hcpcolorado.com](http://www.hcpcolorado.com) with links to Regional HCP Offices throughout Colorado**