	Shared Care Plan		
fo	or Children and Youth with Special	Health Needs	
Child/youth name:		Necessary releases obtained:	□Yes □No
Child/youth likes to be called:		Team meeting date:	
Date of birth:		Meeting location:	
Parent(s):		Referred by:	
Parent phone #:		Other:	
Primary care provider:	Interpreter (if applicable):		
Gender identity: □ M □ F □ Other, pleas	se specify:		
Pronouns: ☐ She/Her ☐ He/Him ☐ Other	er, please specify:		
Child/Family Strengths and Assets			
Child/Family Language and Culture			

Last Updated:

Child/Family Concerns and Goals	
For today:	
For the longer term:	
Brief Medical Summary	
Diagnosis:	
Medications:	
Current Interventions:	Tried Interventions:
Health Care Providers:	
Other Important Medical Information (Allergies/Alerts):	
Other important medical fillorination (Allergica Alerta).	
Preferred Hospital:	Preferred Pharmacy:
Brief Summary of Involvement with Education/Co	ommunity-Based Services

Last Updated:

Team Members Contact List		Note: Initial next to name to note attendance at meeting. Add rows as needed.
Name	Role/Responsibility	Best way to contact
	Family member	
	Primary care provider	
	Education	
	Mental/behavioral health	
	Public health	
	Health plan/insurance	
	Interpreter	

Developed by: Oregon Center for Children and Youth with Special Health Needs (OCCSYHN), August 2016, rev. May 2020 Use with permission – contact OCCYSHN

Phone: 503-494-8303, email: occyshn@ohsu.edu

 $Includes {\it original}\, content\, as\, well\, as\, adapted\, content\, from:$

- Jeanne W. McAllister. May, 2014. Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs: An Implementation Guide. Lucile Packard Foundation for Children's Health.
- Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: Critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA29020090000191TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality. Jun 2011.
- Community Connections Network Shared Care Plan (Community Connections Network is a program of The Oregon Center for Children and Youth with Special Health Needs)

This project is funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Oregon's Title V Maternal and Child Health Block Grant (#B04MC28122, in the amount of \$1,859,482) and the "Enhancing the Systemof Services for Oregon's CYSHCN" grant (#D70MC27548, in the amount of \$300,000). The project receives no nongovernmental funding. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Action Plan Note: Add rows as needed.

- The first goal of the team should be one that is identified by the family as a priority. If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare.

Shared goal:	Who?	Is doing what?	By when?
	This person	Will take this action	By this date
			Date completed:
	This person	Will take this action	By this date
			Date completed:
	This person	Will take this action	By this date
			Date completed:
	This person	Will take this action	By this date
			Date completed:
Date identified:	Notes:		
Date resolved:			

Action Plan Note: Add rows as needed.

- The first goal of the team should be one that is identified by the family as a priority.

 If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare.

Shared goal:	Who?	Is doing what?	By when?
	This person	Will take this action	By this date
			Date completed:
	This person	Will take this action	By this date
			Date completed:
	This person	Will take this action	By this date
			Date completed:
	This person	Will take this action	By this date
			Date completed:
Date identified:	Notes:		
Date resolved:			

Action Plan Note: Add rows as needed.

- The first goal of the team should be one that is identified by the family as a priority. If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare.

Shared goal:	Who?	Is doing what?	By when?
	This person	Will take this action	By this date
			Date completed:
	This person	Will take this action	By this date
			Date completed:
	This person	Will take this action	By this date
			Date completed:
	This person	Will take this action	By this date
			Date completed:
Date identified:	Notes:		
Date resolved:			