

ROLE OF THE CYSHCN PROGRAM SERVICE COORDINATOR

The Service Coordinator is the contact person for the Program and will:

- Review the referral and evaluate if a referral is needed to other resources.
- Gather medical and financial information to determine eligibility for the Program.
- Talk with the participant/family about their current medical treatment.
- Complete a comprehensive assessment of needs for the participant/family.
- Help identify goals with the participant/family.
- Help identify what services are needed to reach these goals.
- Identify funding options and available resources for services needed.
- Help the participant/family identify and communicate with people on the care team for support, advocate for services or equipment, and locate these services.
- Assist the participant/family in accessing a medical home as needed or desired.
- Organize and participate in team conferences with the participant/family.
- Review the plan of care with the participant/family for ongoing needs, make changes as needed, and discuss participant/family satisfaction and compliance with services received.
- Determine at the time of transition or closure if the plan of care has been effective and if services are still needed.

*For Service Coordinator Use Only