The Comprehensive Care Binder

For ____________________________
General Information
General Info

Name: 

Address: 

Birthdate: ________________    SSN: ___________________

Guardian/Conservator #1: 

Address: 

Email: ____________________    Phone: ____________________

Guardian/Conservator #2: 

Address: 

Email: ____________________    Phone: ____________________

Insurance Coverage

Does the individual with AS have any of the following:

☐ Private Insurance
☐ Medicaid
☐ Medicare
☐ Part D Coverage

Extra help for prescription costs:
https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/lower-prescription-costs

☐ Dental Insurance
☐ Vision Insurance

Include copies of all insurance cards with Member ID/Number, Group Number, Policy Holder and Policy Holder DOB
Additional Information

*Is Secondary Insurance provided by a Deeming Waiver?  YES or NO

If YES, be sure to include renewal process and as much information as possible about this process (attach separately).

Are there any regular meetings in regards to insurance and/or waivers?  YES or NO

Medicaid Support Coordination

Who manages Medicaid? __________________________

Who is the support/service coordinator? __________________________

Medicaid Support Coordination

Where does the individual with AS reside? (Home, Group Home, Assisted Living Center, Other)

_______________________________________________________________

Name: _______________________________________________________

Address: _____________________________________________________

_______________________________________________________________

Room Number: ___________________  Phone Number: ___________________

Guest Policies: __________________________________________________

_______________________________________________________________

Cost: ___________________________  How Is It Funded? ___________________

House Director Name and contact info: _____________________________

Company Name and contact Info: _________________________________
Day Program
Does the individual with AS attend a Day Program? (Include Name of Program, Address, Director, Company)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

How is it Funded? _______________________________________________________________________

Transportation Information to and from Day Program. _______________________________________________________________________

List of current caregivers:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role (parent/sibling/teacher/nurse/bus driver/respite)</th>
<th>Phone</th>
<th>Email</th>
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</table>
Medical Information
### Documents

- [ ] Copy of Birth Certificate
- [ ] Genetic Diagnosis Test Results
- [ ] Vaccine Record
- [ ] Past Medical History, including but not limited to seizure log, surgeries, hospitalizations, major illnesses, medications (past and present), previously prescribed meds that were ineffective, seizure protocol and seizure action plan.

### General Doctors/Physicians/Specialists

<table>
<thead>
<tr>
<th>Role</th>
<th>Information</th>
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<tbody>
<tr>
<td>Primary Physician:</td>
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<tr>
<td>Address:</td>
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<td>Phone:</td>
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<td>Fax:</td>
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<tr>
<td>Frequency of Visits/What Months:</td>
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<td>Labs Ordered:</td>
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<td>Medicine Prescribed (dosage/frequency):</td>
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<td>Questions:</td>
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<td>Accepts Insurance:</td>
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<td>Other:</td>
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### Dentist

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<th>Information</th>
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<tbody>
<tr>
<td>Dentist:</td>
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<td>Address:</td>
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<td>Phone:</td>
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<td>Fax:</td>
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<td>Frequency of Visits:</td>
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<td>Sedation Needed:</td>
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<td>Dental Insurance:</td>
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<td>Questions:</td>
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<td>Future Dental Procedures?</td>
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<td>Other:</td>
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</table>
**General Doctors/Physicians/Specialists**

**Neurologist:**
Address: 
Phone:  Fax: 
Frequency of Visits/What Months: 
Labs Ordered: 
Medicine Prescribed (dosage/frequency): 
Questions:  
Accepts Insurance:  
Other: 

**GI Doctor:**
Address: 
Phone:  Fax: 
Frequency of Visits/What Months: 
Labs Ordered: 
Medicine Prescribed (dosage/frequency): 
Questions: 
Accepts Insurance: 
Other: 

**Ophthalmologist:**
Address: 
Phone:  Fax: 
Frequency of Visits:  
Glasses Prescription? 
Vision Insurance: 
Questions: 
Future Eye Exams/Procedures? 
Other: 
General Doctors/Physicians/Specialists

Orthopedist: ________________________________________________________________

Address: ___________________________________________________________________

Phone: __________________________ Fax: __________________________

Frequency of Visits: _________________________________________________________

Reason for Visits: ___________________________________________________________

Questions: __________________________________________________________________

Accepts Insurance: __________________________________________________________

Other: _____________________________________________________________________

Specialist: _________________________________________________________________

Address: ___________________________________________________________________

Phone: __________________________ Fax: __________________________

Frequency of Visits/What Months: _____________________________________________

Labs Ordered: ______________________________________________________________

Medicine Prescribed (dosage/frequency): _______________________________________

Questions: __________________________________________________________________

Accepts Insurance: __________________________________________________________

Other: _____________________________________________________________________

Specialist: _________________________________________________________________

Address: ___________________________________________________________________

Phone: __________________________ Fax: __________________________

Frequency of Visits/What Months: _____________________________________________

Labs Ordered: ______________________________________________________________

Medicine Prescribed (dosage/frequency): _______________________________________

Questions: __________________________________________________________________

Accepts Insurance: __________________________________________________________

Other: _____________________________________________________________________

Additional Info:
Therapies

Type of Therapy: ___________________________ Name: ___________________________
Address: ________________________________________________________________
Phone: ___________________________ Fax: ___________________________
Schedule: ________________________________________________________________
Payment (Insurance or SP): __________________________________________________
Additional Information: ______________________________________________________

Type of Therapy: ___________________________ Name: ___________________________
Address: ________________________________________________________________
Phone: ___________________________ Fax: ___________________________
Schedule: ________________________________________________________________
Payment (Insurance or SP): __________________________________________________
Additional Information: ______________________________________________________

Type of Therapy: ___________________________ Name: ___________________________
Address: ________________________________________________________________
Phone: ___________________________ Fax: ___________________________
Schedule: ________________________________________________________________
Payment (Insurance or SP): __________________________________________________
Additional Information: ______________________________________________________

Type of Therapy: ___________________________ Name: ___________________________
Address: ________________________________________________________________
Phone: ___________________________ Fax: ___________________________
Schedule: ________________________________________________________________
Payment (Insurance or SP): __________________________________________________
Additional Information: ______________________________________________________
### Medications/Prescriptions

<table>
<thead>
<tr>
<th>Name (Generic or Brand)</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Quantity (30/90/120 day supply)</th>
<th>Cost</th>
<th>Pharmacy</th>
<th>Purpose</th>
<th>How is the medication taken?</th>
<th>Preparation Type: (pill, capsule, liquid, chewable, sprinkle, etc)</th>
<th>Comments/Notes: (ex. does it need to be brand necessary)</th>
</tr>
</thead>
</table>
Adaptive Equipment/DME (Durable Medical Equipment)
List any adaptive equipment, devices and durable medical equipment (i.e., walker, wheelchair, car seat/harness, C-Pap machine, orthotics, iPad, communication device, glasses, etc.)

<table>
<thead>
<tr>
<th>Adaptive Equipment/Device</th>
<th>Who Prescribes?</th>
<th>How is it funded? (i.e. prescription from doctor or therapist?)</th>
<th>Who is involved?</th>
<th>Additional Information:</th>
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Important Personal Care Information
Important Personal Care Information

Include information regarding your adult individual with AS personal care and hygiene. Examples include but not limited to:

– Incontinence service for adult diapers and pads
  
  • Name & contact info of company:
  
  • How often do you need to order?

– Hair cuts
  
  • Where does your individual with AS get his/her hair cut?
  
  • Frequency?

– Nail Trim
  
  • Who cuts individual's nails?
  
  • How often?
  
  • Tips:

– Information on shaving (male and female).

– Things to frequently check on (whether individual lives at home or in residential setting):
  
  • Skin assessment: any irritated spots, or infected bumps?
  
  • Frequency of bowel movements
  
  • Changes in behavior
  
  • Changes in appetite

Additional Information:
Weekly Schedule
<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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<th>Saturday</th>
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Regular Reporting Requirements
**Important Personal Care Information**

If required:

Representative Payee Report (ex: filed annually with Social Security Administration. Reflect that his/her income goes toward his/her portion of the mortgage, if applicable)

– Incontinence service for adult diapers and pads

• May change when custodial parent draws SS benefits

• If Representative Payee becomes incapacitated or passes away,

  Social Security needs to be notified immediately.

– Annual report for Guardianship / Mental Hygiene Commission (VARIES BY STATE)

– Medicaid Recertification (varies by state in frequency/need)

Additional Information:
Financial Information
Financial Information – Include any account that directly impacts the individual with AS

Bank/Savings Account: ____________________________
Name(s) on Account: ____________________________________________
Banking Institution: ____________________________________________
Specific Location that you currently use: ____________________________
Account Number: ________________________________________________
Routing Number: ________________________________________________
*or attach voided check
Who Manages account? __________________________________________
What are asset limits to this account? ________________________________
*Balance for Bank/Savings and SS/SSI needs to remain below a certain amount as not to disqualify him/her from any Waiver program and Medicaid.

ABLE Account: For more information visit https://www.ssa.gov/ssi/spotlights/spot-able.html
Name/s on Account: ______________________________________________
Banking Institution: ____________________________________________
Account Number: ________________________________________________
Routing Number: ________________________________________________
Beneficiary: ____________________________________________________
*Include document about Rules of an ABLE account—especially maximum deposit limits AND what it can be used for. Varies by state.

Special Needs Trust
Name/s on Trust: ________________________________________________
EIN: __________________________________________________________
Rules Related to Trust: What can it be used for and tax information
________________________________________________________________

Accountant and/or Attorney Name and Contact Information
________________________________________________________________
**Financial Information** – Include any account that directly impacts the individual with AS

SS/SSI Account/Deposit: ____________________________________________________________

Amount deposited each month: ____________________________________________________

Where is SS/SSI Deposited: _______________________________________________________

Rules for SS/SSI Direct Deposit: _________________________________________________

Who is Representative Payee: _____________________________________________________

*Balance for Bank/Savings and SS/SSI needs to remain below a certain amount as not to disqualify him/her from any Waiver program and Medicaid. For more information visit https://www.ssa.gov/benefits/ssi/*

Other Insurance Policies:

Legal Documents & Paperwork
Legal Documents and Paperwork

– Birth Certificate

– State ID Card

– Passport

– Social Security Card

– Copies of updated Wills for Parents of Individual with AS

– Guardianship Paperwork

– Medical Power of Attorney for Parents

– Trust Documents and Information that Benefit Individual with AS

– Past Tax Return info filed yearly and/or Contact Info of Accountant

– Copies of Any Waiver Documents
Part 9: Employee Payment Process *(If Applicable)*
List & Contact Information of Close Family/Friends
# List and Contact Information of Close Family/Friends

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
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