

Philadelphia Coordinated Health Care

Mission Statement

Philadelphia Coordinated Health Care's mission is to enhance access to community physical and mental health care through education, public health outreach, advocacy and empowerment as well as to improve health care outcomes for individuals with intellectual and developmental disabilities.

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Family HIRS

Section 1

PERSONAL INFORMATION

Name		Phone
Address		County
Date of Birth	Age	SSN

Allergies/ Sensitivities

Does the person have any allergies? Yes No Unsure

What causes the problem (dust, penicillin, etc.)?	What happens (sneezing, rash, etc.)?
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INSURANCE

If this person has any other health insurance and Medical Assistance/Medicaid coverage, the person's Medicaid HMO will be the last insurance billed for health care. The order of billing is as follows:

1. Private/commercial insurance
2. Medicare insurance
3. Medical Assistance/ Medicaid insurance.

Providers of health services will bill all insurers to obtain the maximum allowable amount for the service provided.

Medicaid Information

PA Medicaid/Access Number:	Medicaid HMO Phone Number (if applicable):
Indicate if the person has: <input type="checkbox"/> Americhoice <input type="checkbox"/> Keystone HMO <input type="checkbox"/> HealthPartners <input type="checkbox"/> Straight MA Fee-for-Service I.D. Number: _____	

Medicare Prescription Drug Plan (if applicable)

Name:	Policy Number:
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Medicare (if applicable)

Policy Number: _____ <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Both
Medicare HMO Name: _____ Number: _____

Private/ Commercial/ Other Insurance (if applicable)

Type of Insurance (general health, dental, vision, mental health, etc) _____ Who's name is the insurance under? _____ Insurance Policy Number: _____

Type of Insurance (general health, dental, vision, mental health, etc) _____ Who's name is the insurance under? _____ Insurance Policy Number: _____

MR SUPPORTS

Is this person registered for services with the MH/MR County Office? Yes No

Is this office in the County in which the person resides? Yes No

If not, which County are they registered for services in: _____

Supports Coordinator (if applicable)

Name	Agency/ Office
Address	BSU #
How to contact:	

Agency Supports (residential, day, etc.)

Agency Name	Service Agency Provides
Address	
Agency Phone Number	
Contact Person at Agency	
Best Way to Reach Contact Person	

Agency Name	Service Agency Provides
Address	
Agency Phone Number	
Contact Person at Agency	
Best Way to Reach Contact Person	

FAMILY HEALTH HISTORY

Why It Is Important

An accurate family medical history can have a positive impact on a person's health. Health care providers need complete information to provide comprehensive healthcare.

Family Member	Name	D.O.B.	Living?	If deceased, at what age?	If known, give cause of death
Mother					
Maternal Grandmother					
Maternal Grandfather					
Father					
Paternal Grandmother					
Paternal Grandfather					
Sibling M/F					
Sibling M/F					
Sibling M/F					
Sibling M/F					

FAMILY HEALTH HISTORY con't

Check all that apply. If "other" applies, list the disease or condition to which you are referring.

Disease/ Condition	Mother	Maternal Grand- mother	Maternal Grand- father	Father	Paternal Grand- mother	Paternal Grand- father	Sibling (Indicate Sibling's Name)
Cancer							
TB							
Heart Disease							
Stroke							
High Blood Pressure							
High Cholesterol							
Lung Problems							
Stomach Problems							
Thyroid Problems							
Diabetes							
Kidney Disease							
Sickle Cell Disease							
Anemia							
Migraine Headaches							
Epilepsy							
Arthritis							
Deafness							
Cataracts							
Glaucoma							
Depression							
Bipolar Disorder							
Schizophrenia							
Mental Retardation							
Autism							
Anxiety Disorder(s)							
Other							
Other							
Other							

Check all that apply. If "other" applies, list the disease or condition to which you are referring.

Disease/ Condition	Mother	Maternal Grand- mother	Maternal Grand- father	Father	Paternal Grand- mother	Paternal Grand- father	Sibling (Indicate Sibling's Name)
Cancer							
TB							
Heart Disease							
Stroke							
High Blood Pressure							
High Cholesterol							
Lung Problems							
Stomach Problems							
Thyroid Problems							
Diabetes							
Kidney Disease							
Sickle Cell Disease							
Anemia							
Migraine Headaches							
Epilepsy							
Arthritis							
Deafness							
Cataracts							
Glaucoma							
Depression							
Bipolar Disorder							
Schizophrenia							
Mental Retardation							
Autism							
Anxiety Disorder(s)							
Other							
Other							
Other							

HEALTH CARE DECISION MAKING

Is the person able to make his/her own healthcare decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With Assistance	
If not, who is the person who makes healthcare decisions?	
Name	Relationship
Address	
Home Phone Number	Work Phone Number
Best Way to Contact	
Does this person have a (court appointed) legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, who is that person?	
Name	Relationship
Address	
Home Phone Number	Work Phone Number
Cell Phone/Pager Number	Best Way to Contact

Emergency Contact

Name	Relationship
Address	
Home Phone Number	Work Phone Number
Cell Phone/ Pager Number	Best Way to Contact

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Section 2

DOCTOR and PHARMACY INFORMATION

Primary Health Care

Primary Care Provider	Phone
Address	

Preferred Hospital

Hospital Name	Phone
Address	

Medical Specialists

Name	Specialty
Address	
Phone Number	Fax Number

Name	Specialty
Address	
Phone Number	Fax Number

Name	Specialty
Address	
Phone Number	Fax Number

Name	Specialty
Address	
Phone Number	Fax Number

DOCTOR and PHARMACY INFORMATION con't

Pharmacy

Name	Specialty
Address	
Phone Number	Fax Number

Name	Specialty
Address	
Phone Number	Fax Number

Dentist (see Health Treatment Supports Form section 3)

Name	Specialty
Address	
Phone Number	Fax Number

OTHER HEALTH PROVIDERS

Durable Medical Equipment Company

Name	
Address	
Phone Number	Fax Number

Transportation Company Used

Name	
Address	
Phone Number	Fax Number

Secondary Transportation Company

Name	
Address	
Phone Number	Fax Number

Ambulance Company

Name	
Address	
Phone Number	Fax Number

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Section 3

HEALTH TREATMENT SUPPORTS

Is there anything that is helpful with health exams/ treatments? (i.e. Mother goes with individual on medical appointments)

Are there any health exams/treatments for which sedation is needed? Yes No

If yes, list practitioner(s), frequency, type of sedation and name of the medication given below:

Name of Health Practitioner Seen	Frequency	Medication Given	
		Type of Sedation	Name of Medication
	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	<input type="checkbox"/> By Mouth <input type="checkbox"/> Conscious Sedation <input type="checkbox"/> General Anesthesia	
	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	<input type="checkbox"/> By Mouth <input type="checkbox"/> Conscious Sedation <input type="checkbox"/> General Anesthesia	
	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	<input type="checkbox"/> By Mouth <input type="checkbox"/> Conscious Sedation <input type="checkbox"/> General Anesthesia	
	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	<input type="checkbox"/> By Mouth <input type="checkbox"/> Conscious Sedation <input type="checkbox"/> General Anesthesia	
	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	<input type="checkbox"/> By Mouth <input type="checkbox"/> Conscious Sedation <input type="checkbox"/> General Anesthesia	
	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	<input type="checkbox"/> By Mouth <input type="checkbox"/> Conscious Sedation <input type="checkbox"/> General Anesthesia	
	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	<input type="checkbox"/> By Mouth <input type="checkbox"/> Conscious Sedation <input type="checkbox"/> General Anesthesia	
	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	<input type="checkbox"/> By Mouth <input type="checkbox"/> Conscious Sedation <input type="checkbox"/> General Anesthesia	
	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	<input type="checkbox"/> By Mouth <input type="checkbox"/> Conscious Sedation <input type="checkbox"/> General Anesthesia	

Has this person experienced any adverse effects from sedation/ anesthesia ? Yes No
 If yes, explain:

ANNUAL PHYSICAL EXAMINATION FORM

Please complete all information to avoid return visits.

Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT

Name: _____
 Address: _____
 Sex: Male Female

Date of Exam: _____
 SSN: _____
 Date of Birth: _____
 Name of Accompanying Person: _____

DIAGNOSES/SIGNIFICANT HEALTH CONDITIONS: *(Include a Medical History Summary and Chronic Health Problems List, if available)*

CURRENT MEDICATIONS: *(Attach a second page if needed)*

Medication Name	Dose	Frequency	Diagnosis	Prescribing Physician Specialty	Date Medication Prescribed

Does the person take medications independently? Yes No

Allergies/Sensitivities: _____

Contraindicated Medication: _____

IMMUNIZATIONS:

Tetanus/Diphtheria *(every 10 years)*: ____/____/____ Type administered: _____
 Hepatitis B: #1 ____/____/____ #2 ____/____/____ #3 ____/____/____
 Influenza (Flu): ____/____/____
 Pneumovax: ____/____/____
 Other: *(specify)* _____

TUBERCULOSIS (TB) SCREENING: *(every 2 years by Mantoux method; if positive initial chest x-ray should be done)*

Date given _____ Date read _____ Results _____
 Chest x-ray (date) _____ Results _____

Is the person free of communicable diseases? Yes No *(If no, list specific precautions to prevent the spread of disease to others)*

OTHER MEDICAL/LAB/DIAGNOSTIC TESTS:

GYN exam w/PAP: Date _____ Results _____
(women over age 18)
 Mammogram: Date: _____ Results: _____
(every 2 years- women ages 40-49, yearly for women 50 and over)
 Prostate Exam: Date: _____ Results: _____
(digital method-males 40 and over)
 Hemocult Date: _____ Results: _____
 Urinalysis Date: _____ Results: _____
 CBC/Differential Date: _____ Results: _____
 Hepatitis B Screening Date: _____ Results: _____
 PSA Date: _____ Results: _____
 Other *(specify)* _____ Date: _____ Results: _____
 Other *(specify)* _____ Date: _____ Results: _____

HOSPITALIZATIONS/SURGICAL PROCEDURES:

Date	Reason	Date	Reason

Part Two: GENERAL PHYSICAL EXAMINATION*Please complete all information to avoid return visits.*

Blood Pressure: _____ / _____ Pulse: _____ Respirations: _____ Temp: _____ Height: _____ Weight: _____

EVALUATION OF SYSTEMS

System Name	Normal Findings?	Comments/Description
Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mouth/Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Head/Face/Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Breasts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lungs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Extremities	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Abdomen	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastrointestinal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Musculoskeletal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Integumentary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Renal/Urinary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reproductive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lymphatic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Endocrine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nervous System	<input type="checkbox"/> Yes <input type="checkbox"/> No	
VISION SCREENING	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is further evaluation recommended by specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No
HEARING SCREENING	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is further evaluation recommended by specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Comments:Medical history summary reviewed? Yes No

Medication added, changed, or deleted: (from this appointment) _____

Special medication considerations or side effects: _____

Recommendations for health maintenance: (include need for lab work at regular intervals, treatments, therapies, exercise, hygiene, weight control, etc.) _____

Recommendations for manual breast exam or manual testicular exam: (include who will perform and frequency) _____

Recommended diet and special instructions: _____

Information pertinent to diagnosis and treatment in case of emergency: _____

Limitations or restrictions for activities (including work day, lifting, standing, and bending): No Yes (specify) _____Does this person use adaptive equipment? No Yes (specify): _____Change in health status from previous year? No Yes (specify): _____This individual is recommended for ICF/MR level of care? (see attached explanation) Yes NoSpecialty consults recommended? No Yes (specify): _____Seizure Disorder present? No Yes (specify type): _____ Date of Last Seizure: _____

Name of Physician (please print) _____

Physician's Signature _____

Date _____

Physician Address: _____

Physician Phone Number: _____

IMMUNIZATIONS

This list is only a general grouping. If other immunizations have been administered, please list them in the "other" section.

Immunization	Date Given	Date Given	Date Given	Date Given
DTP (Dypthaeria Tetanus Pertussis)				
Td (Tetanus)				
IPV (Polio)				
MMR (Measels Mumps Rubella)				
Hepatitis B Series				
Lymerix (Lymes)				
PPD /Mantoux (Tuberculosis)				
PCV Pneumovax (Pneumonia)				
Flu Shot				
Varicella Varivax (Chicken Pox)				
Other				
Other				

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Section 4

CHRONIC HEALTH PROBLEMS

A CHRONIC health condition is a health condition that a person has for more than six months and is characterized by frequent reoccurrence (for example, Mental Retardation).

You can contact your medical practitioner to learn the name of the diagnosis and axis

Condition List

Date of Onset (if known)	Axis I – Psychiatric Disorders/Diagnosis (ex: diagnosis of depression)
	Axis II – Mental Retardation and Personality Disorders

BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION

PART THREE: PHYSICIAN'S REPORT (To be completed by physician prescribing psychotropic medication)

INDIVIDUAL:

DATE OF PRESENT PSYCHOTROPIC MED REVIEW:	DATE OF NEXT PSYCHOTROPIC MED REVIEW:
--	---------------------------------------

PHYSICIAN'S AGREEMENT WITH CURRENT DIAGNOSES AND TARGET SYMPTOMS: (see Page 1 and Page 2)
 Do the diagnosis(es) in Part 1 and the target symptoms in Part 2 remain as indicated on Part 1: *Health Services Report* and Part 2: *Behavior Support Treatment Report*? Yes No If NO, please change to:

TREATMENT GOALS (Regarding Target Symptoms listed on Parts 1 and 2):	PROGRESS TOWARD GOALS:
--	------------------------

- | | | | |
|---|------------------------------|-----------------------------|--|
| ◆ Psychotropic medications are necessary? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| ◆ Psychotropic medication dosages are within usual range? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| ◆ Number of drugs conforms to accepted standards? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| ◆ Are medication side-effects present? (e.g. sedation, ataxia, dyscrasia) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| ◆ Screening test performed (e.g. AIMS)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| ◆ Symptoms of T.D. or other E.P.S.? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| ◆ Medication reduction plan considered? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

PHYSICIAN'S ORDERS

MEDICATION CHANGE: No Yes (provide information below)

<i>NEW MEDICATION (List medication, dosage & frequency)</i>			REASON FOR NEW MEDICATION
Medication	dosage	frequency	Medication Education Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No
1)			
2)			
3)			

<i>MEDICATION CHANGE (List med., dosage & frequency)</i>			REASON FOR MEDICATION CHANGE
Medication	dosage	frequency	Medication Education Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No
1)			
2)			
3)			

<i>MEDICATION DISCONTINUED (List med., dosage & frequency)</i>			REASON FOR MEDICATION DISCONTINUATION
Medication	dosage	frequency	Medication Education Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No
1)			
2)			
3)			

LAB STUDIES, DIAGNOSTIC TESTS AND FREQUENCIES: Metabolic screening done? Yes No Date: _____

COMMENTS/CHANGES/REASONS/AREAS OF CONCERN:

My signature below indicates that I have reviewed the Health Services and Behavior Support Treatment Reports. I have reviewed my recommendations, as well as the consequences to the individual for not following my recommendations with all parties attending this review. [This form can be completed for any appointment but psychotropic medications MUST BE REVIEWED EVERY 90 DAYS MINIMUM.]

Physician's Printed Name, Signature and Date:	Clinician: Signature, Title and Date:
---	---------------------------------------

Consumer's Consent for Psychotropic Medication: Signature and Date:

Accompanying Person's Printed Name, Signature and Date:

SWALLOWING/DYSPHAGIA SCREEN

Most of us never think of the possibility of not being able to eat or drink safely. It does happen and in very large numbers. *Dysphagia* (dis-FA'jE-a) is the term that means difficulty in swallowing. Many adults with developmental disabilities have or may develop difficulty swallowing.

This screening tool was created to assist you in the identification of possible problems with swallowing. If you fill out this tool and you find several boxes checked, we suggest that you bring it to your case manager, care staff, or physician's attention right away.

- Frequent episodes of gagging, choking, or coughing
- Coughing or choking during eating or drinking
- Excessive drooling
- Gurgling voice after eating or drinking
- Watery eyes during or after eating or drinking
- Frequent upper respiratory infections or pneumonia
- Swallow food whole
- Regurgitation after meals, especially while reclining
- Eating rapidly
- Difficulty chewing or swallowing
- Storing food in mouth
- Loss of food from mouth or nose during or after meals
- Unusual head or body movements during drinking or eating
- Difficulty maintaining posture during or after eating

SEIZURE CHART

1. NAME:	DATE:
2. ADDRESS:	TIME: Duration:
3. OBSERVER'S NAME:	LOCATION:

☞ Check the appropriate numbers and attach to Incident Reporting form ☞

A. Posture at onset of seizure

- Standing
- Sitting
- Walking
- Lying Down
- Other (*see comments*)

B. Color

- Pale
- Flushed
- Blue
- No Change

C. Level of Consciousness

- Drowsy
- Confused
- Unresponsive
- Unconscious
- Other (*see comments*)

D. Eyes

- Open
- Closed
- Rolled Up
- Fixed Staring
- Blinking

E. Extremities Involved

- All Extremities
- Arms: Right Left
- Legs: Right Left
- Stiff
- Relaxed
- Twitching (*mild motor movements*)
- Jerking (*intense motor movements*)
- a-Intermittent
- b-continuous

F. Elimination

- Individual experienced incontinence
- Bowel
- Bladder
- In Toilet? Yes No

G. Breathing

- Normal
- Difficult

H. Other Signs

- Sweating
- Tongue Biting
- Dropping of Head
- Sudden Personality Change
- Repetitive Purposeless Acts (*see comments*)
- Facial Twitching
- Excessive Saliva or Drooling
- Speech Changes

I. First Aid Care

- Prevented Fall
- Actually Intervened to Prevent Fall
- b-Precautionary Management
- Supported Head
- Placed on Side
- Clothing Loosened
- Other (*see comments*)

J. After Seizure

- Alert
- Drowsy
- Confused
- Upset
- Talkative
- Brief Sleep, Time: _____
- Physical Complaint (*see comments*)

K. Injuries

Describe:

L. Injuries

Due to a fall? Yes No If Yes, what part of body absorbed impact of the fall?

Describe what the person was doing immediately prior to the seizure:	
COMMENTS:	
SIGNATURE OF PERSON COMPLETING REPORT:	DATE:

ANNUAL SEIZURE SUMMARY

Name:	Year:
Type of Seizure(s):	Person completing this form:

Please mark the total number of seizures each day of the month on the chart below:

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JAN																															
FEB																															
MAR																															
APR																															
MAY																															
JUN																															
JUL																															
AUG																															
SEP																															
OCT																															
NOV																															
DEC																															

Total Number of Seizures, by month:

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

COMMENTS: <i>(Date and note any medication changes, lab results, significant illnesses, etc. that could possibly effect seizure frequency or severity—use other side if necessary)</i>

Date completed: _____

Signature: _____

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Section 5

WELLNESS SCHEDULE

ANA Screening Guidelines
Adult Preventive Care Time Line

	Years of Age	18	25	30	35	40	45	50	55	60	65	70	75+
Blood Pressure		every 2 years											
Height and Weight		periodically											
Cholesterol		every 5 years											
Hearing													periodically
Mammography													every 1 to 2 years (women)
Pap Smear		every 2 to 3 years (women)											
Prostate-specific antigen													annually (men)
Sigmoidoscopy													every 3 to 5 years
Stool occult blood													annually
Urinalysis													periodically
Dental		annually											
Vision/ glaucoma													every 2 years
Breast		every 1 to 3 years (women) annually (women)											
Cancer (thyroid, mouth, skin, ovaries, testicles, lymph nodes, rectum [40+], prostate [men, 50+])		every 3 years annually											
Tetanus-diphtheria		every 10 years											
Pneumococcal													once
Influenza													annually
Smoking, alcohol, drugs, sexual behavior, AIDS, guns, family planning, injuries, occupational health, nutrition, physical activity, violence and folate (women 12-45), aspirin (men 40+), estrogen (women 45+)		periodically											

Check up visits with a physician or other health care provider are important for good health. Most authorities recommend these visits every 1 to 3 years until age 65 and yearly thereafter. Each individual should speak with a physician or other health care provider about the proper schedule of checkup visits. This chart shows the different types of preventative care that are needed at each age. Please note: Recommended intervals for each type of preventative care may vary among authorities. Individuals with special risk factors may need more frequent and additional types of preventative care.

Risk Factor	Preventative Service(s) needed:
Diabetes	Eye, foot examinations, urine test
Drug Abuse	AIDS, TB tests, hepatitis immunization
Alcoholism	Influenza, pneumococcal immunizations, TB
Overweight	Blood sugar test
Homeless, recent refugee immigrant	TB test
High risk sexual behavior	AIDS, syphilis, gonorrhea, chlamydia tests

Health Maintenance Schedule

Type of Visit	Licensing Regulations	Doctor Recommends
Physical Exam	Yearly	Yearly
Eye Exam	Yearly screen with physical	As needed
Dental Exam	Yearly	Every six months
GYN Exam	Yearly with PAP	Yearly with PAP
Hearing Screen	Yearly with physical	Yearly with physical
Skin Check		Yearly
Breast Exam		Monthly
Testicular Exam		Monthly
Blood Pressure	Yearly with physical	Yearly as needed
Mammogram	Every 2 years 40-49, Yearly >50years	Every 2 years, <50 Yearly >50 years
PSA for prostate cancer	Yearly over 40 years with digital exam	Yearly over 40 years with digital exam
Colonoscopy		As recommended by physician

Resource List of Advocacy Groups ***Southeast Regional and Statewide***

The Advocacy Alliance

877-315-6855 •

www.theadvocacyalliance.org

Our mission is to promote mental wellbeing, prevent mental illness, and advocate for the rights of and provide services to persons who are mentally ill and mentally retarded.

American Council of the Blind

Pennsylvania Chapter:

800-736-1410 • www.trfn.clpgh.org/pcb/

National Office:

800-424-8666 • www.acb.org

The American Council of the Blind is the nation's leading membership organization of blind and visually impaired people. It was founded in 1961 and incorporated in the District of Columbia.

The Autism Society of America (ASA)

Greater Philadelphia Chapter:

610-358-5256 • www.asaphilly.org

National Office:

1.800.3AUTISM • www.autism-society.org

The mission of the Autism Society of America is to promote lifelong access and opportunity for all individuals within the autism spectrum, and their families, to be fully participating, included members of their community. Education, advocacy at state and federal levels, active public awareness and the promotion of research form the cornerstones of ASA's efforts to carry forth its mission.

Department of Education

Pennsylvania: www.pde.state.pa.us

National: 800-USA-LEARN •

www.ed.gov

Disabilities Law Project

215-238-8070 • www.dlp-pa.org

The Disabilities Law Project (DLP) is a nonprofit Pennsylvania law firm that provides free legal assistance to people with disabilities, their families, and their organizations. DLP's main purpose is to advocate for the civil rights of persons with mental and physical disabilities, especially their right to live as integral parts of their communities. DLP works to ensure that people with disabilities have equal and unhindered access to employment, transportation, public accommodations, and government services; to enforce their rights to vocational, habilitative, post-secondary educational, health, and other services; and to protect them from abuse and neglect.

Epilepsy Foundation of America

Eastern Pennsylvania Chapter:

800-332-1000

www.epilepsyfoundation.org

National Office:

215-6294997

The Epilepsy Foundation is a national, charitable organization, founded in 1968 as the Epilepsy Foundation of America. The only such organization wholly dedicated to the welfare of people with epilepsy, our mission is simple: to work for children and adults affected by seizures through research, education, advocacy and service.

Health Care Quality Units (HCQU's)

Southeast Regional: Philadelphia
Coordinated Health Care
123 South Broad Street
22nd Floor
Philadelphia, PA 19109
215-546-0300
www.pchc.pmhcc.org

South Central PA:
PNC Bank East Suite
9 West Chocolate Avenue
Hershey, PA 17033
717-531-0528

AE Community Health Connections
101 East Diamond Street
Suite 100
Butler, PA 16001
724-283-0990
www.aechc.org

Central PA:
100 N. Academy Ave.
Danville, PA 17822
570-271-7240
www.geisinger.org

Eastern PA:
744 North 19th Street
Allentown, PA 18104
610-435-2700
www.theadvocacyalliance.org

Northeast PA:
846 Jefferson Ave.
PO Box 1368
Scranton, PA 18501
570-342-7762
www.theadvocacyalliance.org

Health Care Quality Units [HCQUs] serve as the entity responsible to county MR programs for the overall health status of individuals receiving services in the county programs. HCQUs work to support and improve the state MR

community system by building capacity and competency to meet the physical and behavioral health care needs of people with developmental disabilities living in Pennsylvania. The primary activities of HCQUs include: assessment of individual health and systems of care; providing clinical health care expertise to counties and residential and day program providers; health related training; integrating community health care expertise to counties and residential and day program providers; health related training: integrating community health care resources with state and regional quality improvement structures and processes and health advocacy. The ultimate goal of the HCQUs is to assure that the individuals served by each county MR program are as healthy as they can be, so that each individual can fully participate in community life.

Learning Disabilities Association of America

Pennsylvania Affiliate: 610-458-8193
www.ldnatl.org/Affiliates/PA/LDAP.htm
National Office: 412-341-1515 •
www.ldantl.org

LDA is the only national organization devoted to defining and finding solutions for the broad spectrum of learning disabilities. LDA is the largest non-profit volunteer organization advocating for individuals with learning disabilities. LDA has 50 state affiliates and more than 600 local chapters in 50 states, Washington DC, and Puerto Rico. Membership totals more than 50,000.

Liberty Resources

www.libertyresources.org
We are a non-profit, consumer driven organization that advocates and

promotes Independent Living for persons with disabilities. More than fifty percent of our board as well as fifty percent of our employees are persons with disabilities.

Parent Education Network

800-522-5827 • www.parentenet.org
PEN is Pennsylvania's statewide Parent Training and Information Center. Much of the information included in this site is designed to support Pennsylvania parents of children with special needs, but information and links are included on Federal Special Education, National Disability Issues and Resources, Special Education Legal Links, Transportation, and Travel that will also pertain to parents and individuals with disabilities in other states.

Parent's Involved Network (PIN)

800-688-4226 • www.pinofpa.org
Parents Involved Network of Pennsylvania (PIN) is an organization that assists parents or caregivers of children and adolescents with emotional and behavioral disorders. PIN provides information, helps parents find services and will advocate on their behalf with any of the public systems that serve children. These include the mental health system, education, and other state and local child-serving agencies.

Parent to Parent of Pennsylvania/ Special Kids Network

800-986-4550 • www.parenttoparent.org
Parent to Parent of Pennsylvania is a

network created by families for families of children and adults with special needs. We connect families in similar situations with one another so that they may share experiences, offer practical information and/or support.

Pennsylvania Developmental Disabilities Council

717-787-6057 • www.padcc.org
The Pennsylvania Developmental Disabilities Council is a group made up of people with disabilities, family members, advocates, and state department representatives who work to create favorable conditions for people with developmental disabilities and their families in the Commonwealth.

Pennsylvania Education Law Center

215-238-6970 • www.elc-pa.org
The Education Law Center (ELC) is a non-profit legal advocacy organization dedicated to ensuring that all of Pennsylvania's children have access to a quality public education.

Pennsylvania Health Law Project

800-274-3258 • www.phlp.org
PHLP is a nationally recognized expert and consultant on access to health care for low-income consumers, the elderly, and persons with disabilities. For more than a decade, PHLP has engaged in direct advocacy on behalf of individual consumers while working on the kinds of health policy changes that promise the most to the Pennsylvanians in greatest need.

Pennsylvania Parents and Caregivers Resource Network

888-5-PARENT • www.ppcrn.org
We are a statewide cross-disability, grassroots network that supports parents' and caregivers' efforts to help their children and adult family members with developmental disabilities. PPCRN helps them to form local groups and to network with other parents in their regions and across the state. We promote inclusionary practices in all areas of life among parents and caregivers of children and adults with developmental disabilities.

Pennsylvania Protection and Advocacy

717-236-8110 • www.ppainc.org
Pennsylvania Protection and Advocacy, Inc. (PP&A, Inc.) is a federally funded, nonprofit agency responsible for providing protection and advocacy services to people with disabilities.

Pennsylvania Society for the Advancement of the Deaf (PSAD)

www.psadweb.org
PSAD fights discrimination and public misconceptions in our everyday lives by lobbying for the establishment of a deaf/hard of hearing bill of rights with local, state, and federal government through different agencies and organizations.

Pennsylvania Special Education ConsultLine

800-879-2301
www.pde.state.pa.us/special_edu/site/default.asp

Help for families and advocates of children with special needs about special education regulations, school related concerns, and procedural safeguards.

Pennsylvania Vocational Rehabilitation Agency

800-622-2842 • www.dli.state.pa.us
Coordinates and provides counseling, evaluation, and job placement services for people with disabilities.

Speaking for Ourselves

610-825-4592 • www.speaking.org
Speaking For Ourselves, a nonprofit organization, is a pioneer in self-advocacy for people with disabilities. Our mission is to find a voice for ourselves. Teach the public about the needs and wishes and potential of people with disabilities. Speak out on important issues and Support each other through sharing, leadership development and helping and encouraging each other.

Temple University Institute on Disabilities

www.temple.edu/instituteondisabilities

The Institute on Disabilities at Temple University is one of the sixty-one University Centers for Excellence in Developmental Disabilities funded by the Administration on Developmental Disabilities U.S. Department of Health and Human Services. The mission of the Institute on Disabilities is that, in partnership with people with disabilities, families and allies from diverse

cultures, we work to change systems so that people can live, learn, work and play in the communities of their choice. This mission is accomplished through training, technical assistance, services and supports, research, dissemination, and advocacy.

Visions for Equality

215-923-3349

www.visionforequality.org

A non-profit organization that was established in 1996 for the purpose of providing monitoring and advocacy services for people with mental retardation and their families. Vision for Equality's mission is to assist and empower people with disabilities and their families to seek quality and satisfaction in their lives and equal access to supports and services. Five major program areas are: 1. Embreeville Consumer and Family Satisfaction Teams; 2. court-related and general Advocacy; 3. a Training Department; 4. the Pennsylvania Waiting List Campaign including community education services; 5. Independent Monitoring for Quality (IM4Q).

National

American Cancer Society

1-800-ACS-2345 • www.cancer.org
The American Cancer Society (ACS) is a nationwide, community-based voluntary health organization. With chartered divisions throughout the country and over 3,400 local offices, the American Cancer Society (ACS) is

committed to fighting cancer through balanced programs of research, education, patient service, advocacy, and rehabilitation.

Americans with Disabilities Act Information

www.usdoj.gov

The ARC

301-565-3842 • www.thearc.org

The Arc is the national organization of and for people with mental retardation and related developmental disabilities and their families. It is devoted to promoting and improving supports and services for people with mental retardation and their families. The association also fosters research and education regarding the prevention of mental retardation in infants and young children. The Arc is people - people with mental retardation and related developmental disabilities, parents and other family members, and friends of people with mental retardation and professionals who work with them.

CONNECT Information Service

800-692-7288

The Consortium for People with Developmental Disabilities

202-783-2229

www.c-c-d.org

The Consortium for Citizens with Disabilities is a Coalition of national consumer, advocacy, provider and professional organizations headquartered in Washington, D.C. Since 1973, the CCD has advocated on behalf of people of all

ages with physical and mental disabilities and their families. CCD has worked to achieve federal legislation and regulations that assure that the 54 million children and adults with disabilities are fully integrated into the mainstream of society.

Council for Exceptional Children

703-620-3660 • www.cec.sped.org
Pennsylvania CEC: www.pfcec.org
The Council for Exceptional Children (CEC) is the largest international professional organization dedicated to improving educational outcomes for individuals with exceptionalities, students with disabilities, and/or the gifted. CEC advocates for appropriate governmental policies, sets professional standards, provides continual professional development, advocates for newly and historically underserved individuals with exceptionalities, and helps professionals obtain conditions and resources necessary for effective professional practice.

Easter Seal Society

SE Pennsylvania:
www.easterseals-sepa.org
National: 312-726-6200 • www.easterseals.org
Easter Seals has been helping individuals with disabilities and special needs, and their families, live better lives for more than 80 years. Whether helping someone improve physical mobility, return to work or simply gain greater independence for everyday living, Easter Seals offers a variety of services to help people with disabilities address life's challenges and achieve personal goals.

EDLAW

www.edlaw.net
The EDLAW Center was established to provide assistance on a systemic level to attorneys who represent parents of children with disabilities. It is premised on the recognition that, while securing an appropriate education for any single child with a disability is important, changes on a systemic level are necessary to enable all children with disabilities to obtain the free appropriate public education promised to them by the law.

IDEA Practices

877-CEC-IDEA • www.ideapractices.org
The IDEA Partnerships are four national projects funded by the U.S. Department of Education's Office of Special Education Programs (OSEP) to deliver a common message about the landmark 1997 reauthorization of the Individuals with Disabilities Education Act (IDEA). The IDEA Partnerships, working together for five years, inform professionals, families and the public about IDEA '97 and strategies to improve educational results for children and youth with disabilities.

National Down Syndrome Congress

1-800-232-NDSC • www.ndsccenter.org
The purpose of the NDSC is to promote the interests of persons with Down syndrome and their families through advocacy, public awareness, and information dissemination on all aspects of Down syndrome. The NDSC is financially supported primarily through membership dues and individual contributions.

National Down Syndrome Society

800-221-4602 • www.ndss.org

The National Down Syndrome Society was established in 1979 to ensure that all people with Down syndrome have the opportunity to achieve their full potential in community life. Since that time, this not-for-profit organization has become the largest non-governmental supporter of Down syndrome research in the United States.

National Organization on Disability

202-293-5960 • www.nod.org

The National Organization on Disability, celebrating its 20th anniversary in 2002, promotes the full and equal participation and contribution of America's 54 million men, women and children with disabilities in all aspects of life.

Reed Martin, JD – Special Education Law

www.reedmatin.com

Reed Martin is an attorney with over 34 years experience in special education law and recognized as one of the nation's leading experts.

Tourette Syndrome Association

718-224-2999 • www.tsa-usa.org

Founded in 1972 in Bayside, New York, the Tourette Syndrome Association, Inc., or TSA, is the only national voluntary non-profit membership organization in this field. Its mission is to identify the cause of, find the cure for and control the effects of this disorder.

United Cerebral Palsy

800-872-5827 • www.ucpa.org

UCP is the leading source of information on cerebral palsy and is a pivotal advocate for the rights of persons with any disability. As one of the largest health charities in America, UCP's mission is to advance the independence, productivity and full citizenship of people with cerebral palsy and other disabilities.

US Office of Special Education Programs

202-205-5507•

www.ed.gov/offices/OSERS/OSEP/

OSEP is dedicated to improving results for infants, toddlers, children and youth with disabilities ages birth through 21 by providing leadership and financial support to assist states and local districts.

Wright's Special Education Law

www.wrightslaw.com

Parents, advocates, educators, and attorneys come to Wrightslaw for accurate, up-to-date information about advocacy for children with disabilities. You will find hundreds of articles, cases, newsletters, and resources about special education law and advocacy in the Advocacy Libraries and Law Libraries.