<Date>  
  
  
**Important Medica Information**<Member Name>

<Address 1>

<Address 2> <City, state, zip>

**Your Care Plan**

Dear <Member name>,

I am your Medica Care Coordinator and I visited you at <SNF Name> on <date of assessment> to complete your Medica Health Assessment.

I reviewed your Facility Care Plan and assessment and all identified needs have goals present

I reviewed your Facility Care Plan and assessment and we identified these additional goal(s):

* \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I will plan to follow up:

Once a month

Every 3 months

Every 6 months

Other \_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_ \_\_ \_\_\_\_ \_\_ \_\_\_\_ \_\_ \_\_\_\_ \_\_ \_\_\_\_ \_\_ \_\_\_\_ \_\_ \_\_\_\_ \_\_ \_\_\_\_ \_\_ \_\_\_\_ \_\_

<Free text for member specific information.>

**Questions?**

If you have any questions or want to discuss your health care needs, call me at <CC phone number> <Monday-Friday> between <CC hours of operation>. TTY: **711**.

Sincerely,

<CC name>, <Credentials>

<County/Care System/Agency name>

<CC phone number> <CC email address>

cc: member record, Skilled Nursing Facility

Medica DUAL Solution® is an HMO D-SNP that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in Medica DUAL Solution depends on contract renewal.

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