**My Care Plan and Community Support Plan**

**Information about Me**

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| --- | --- | --- | --- |
| **Name:**  | **My Health Plan ID Number:**  | **My Health Plan Name:** | **Today’s Date:** |
| **Phone #:**  | **My DOB:**  | **Product Enrollment Date:**  |
| **My Address:** | **Rate Cell:**  | **Diagnosis:**  |
| **Date of My Assessment Visit:** **Assessment Type:****[ ]** Initial Health Risk Assessment[ ]  Annual Reassessment[ ]  Change in My Needs [ ]  Other       |
| **Is there an Advance Directive or Health Care Directive in place?** **[ ]** Yes [ ]  No**Was Advance Directive/Health Care Directive discussed:** **[ ]** Yes [ ]  NoIf no, reason:       | **My primary language is:****[ ]** English [ ] Hmong [ ]  Spanish[ ]  Somali [ ]  Vietnamese [ ] Russian[ ]  Other (*Type in the “other” language*)**I need an interpreter:** **[ ]  Yes** **[ ]  No****Name and number of Interpreter (*If applicable*):**  |

**My Care Team (Interdisciplinary Care Team-ICT)**

|  |  |  |
| --- | --- | --- |
| **Care Coordinator/Case Manager:****Name:** **Phone #:**  | **Primary Physician:** **Phone #:** **Fax #:**  | **Clinic:** |
| **Emergency Contact Name & Phone:** | **My Representative is:****They can be contacted for:** |
| **I have a Mental Health Targeted Case Manager:** **[ ]  Yes** **[ ] No****Name of MHTCM:** **Phone Number of MHTCM:**  |
| **Other Care Team Members Name** | **Relationship to me** | **Give Copy of Care plan?** | **Date sent** |
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**What’s Important to Me? *(e.g. living close to my family, visiting friends)***

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| Initial/Annual:      |
| Update:       |

**My Strengths: *(e.g. skills, talents, interests, information about me)***

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| Initial/Annual:       |
| Update:       |

**My Supports and Services: *(What do I want help with? Service and support I requested? From whom?***

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| Initial/Annual:       |
| Update:       |

**Caregiver:**

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| Informal Caregiver listed on HRA/LTCC: *(Caregivers are unpaid person(s) providing services)*[ ]  Yes [ ]  NoIf yes, the Caregiver Assessment Form was completed by:[ ]  Face-to-Face [ ]  Telephone [ ]  Mail [ ]  Declined Date Completed:       |

**Managing and Improving My Health**

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| **Screening for my health** |  |
|  | **Check if educational conversation took place with me** | **Goal is needed** | **Check if N/A, contraindicated, declined** | **Notes** |
| Annual Preventive Health Exam  | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Mammogram (Within past 2 years ages 65-75) | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Continence needs (Evaluated by a physician?) | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Colorectal Screening(Up to age 75) | **[ ]**  | **[ ]**  | **[ ]**  |  |
| At Risk for Falls (Afraid of falling, has fallen in the past). | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Pneumovax (*Immunize at age 65 if not done previously. Re-immunize once if 1st pneumovax was received more than 5 years ago & before age 65)* | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Flu shot *(Annually ages 50+ and persons at high risk.)* | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Tetanus Booster *(Once every 10 years)* | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Hearing Exam  | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Vision Exam | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Dental Exam  | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Calcium Vitamin DRx for Ca Vitamin D?(as directed by physician) | **[ ]**  | **[ ]**  | **[ ]**  |  |
| AspirinRx for Aspirin?(as directed by physician) | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Blood Pressure:(Blood Pressure Goal is <140/80 to age 75. After 75 based on individual) | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Cholesterol check  | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Diabetic routine checks as recommended by physician (Discuss with my care team: Hypertension, Neuropathy, Eye exam, Cholesterol, A1C) | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Other: | **[ ]**  | **[ ]**  | **[ ]**  |  |
| Mental Health Diagnosis (If applicable):       [ ]  N/A | Managed by a Health Professional? [ ]  Yes [ ]  No(Psychiatrist, Psychologist, Primary Care Physician)Need Goal? [ ]  Yes [ ]  No [ ]  Declined |
| My Medications | I need help with my medications?[ ]  Yes [ ]  No [ ]  N/A (no medications used)If yes, create a goal |
| List of Medications *(If not on LTCC)* |       |
| Safe Disposal of Medication Discussion | I have discussed safe disposal of medications and was provided supporting documents.[ ]  Yes [ ]  N/A Comments:       |
| Health Improvement Referral | [ ]  Yes [ ]  Declined [ ]  N/A Diagnosis:       |
| Hospitalizations (*In past year number and reason, date(s) if available)* |  |
| ER visits (In past year number and reason for visit; *dates, if available)* |  |
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**My Goals**

Discuss with Care Coordinator, goals for: my everyday life (taking care of myself or my home); my relationships and community connections; my future plans, my health, my safety; my choices.

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| --- | --- | --- | --- | --- | --- |
| **Rank by** **Priority**  | **My Goals**  |  **Support(s) Needed** | **Target Date** | **Monitoring Progress/Goal Revision date** | **Date Goal Achieved/ Not Achieved****(Month/Year)** |
| **[ ]  Low****[ ]  Medium****[ ]  High** |  |  |  |  |  |
| **[ ]  Low****[ ]  Medium****[ ]  High** |  |  |  |  |  |
| **[ ]  Low****[ ]  Medium****[ ]  High** |  |  |  |  |  |
| **[ ]  Low****[ ]  Medium****[ ]  High** |  |  |  |  |  |
| **[ ]  Low****[ ]  Medium****[ ]  High** |  |  |  |  |  |
| **[ ]  Low****[ ]  Medium****[ ]  High** |  |  |  |  |  |
| **[ ]  Low****[ ]  Medium****[ ]  High** |  |  |  |  |  |

**Additional updates/notes about my goals:**

**Barriers to meeting my goals**

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| **Initial/Annual:** |
| **Update:** |
| **[ ]  No barriers identified**  |

**My follow up plan:**

Care Coordinator/Case Manager follow-up will occur:

[ ]  Once a month

[ ]  Every 3 months

[ ]  Every 6 months

[ ]  Other

**Purpose of Care Coordinator contact:**

**I can contact my Care Coordinator to help me with my medical, social or everyday needs. I should contact my Care Coordinator when:**

* Changes happen with my health
* I have a scheduled procedure or surgery or I am hospitalized
* I have experienced falls in my home or community
* I can no longer do some things that I had been able to do by myself (such as meal preparation, bathing, bill paying)
* If I need additional community services such as: equipment for bathroom safety or home safety; assistance with finding a new living situation (senior apartment); information about topics such as staying healthy, preventing falls, and immunizations.
* I need help finding a specialist
* I need help learning about my medications
* I would like information to help myself and my family make health care decisions
* I would like changes to my care plan or my services and supports
* I would like to talk about other service options that can meet my needs
* I am dissatisfied with one or more of my providers

**My Safety Plan**

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| **My safety concerns were discussed with my Care Coordinator: [ ]  Yes** **Notes about safety concerns:** **My plan for managing risks that I have discussed with my Care Coordinator is:**       |
| **Emergency Plan:****In the event of an emergency, I will (check all that apply):****[ ]  Call 911** **[ ]  Use Emergency Response Monitoring System****[ ]  Call Emergency Contact****[ ]  Call Other Person Name:** **Phone:** **[ ]  Other (describe)** **Self Preservation/Evacuation Plan:****If I am unable to evacuate on my own in an emergency, my plan is to:** **If other concerns or plans, describe:**  |
| **Essential Services Backup Plan: (*when providers of essential services are unavailable; essential services are services that if not received, health and safety would be at risk)*****I am receiving essential services [ ]  Yes [ ]  No****Essential services I am receiving:****If Yes, describe provider’s backup plan, as agreed to by me:**  |
| **Community-Wide Disaster Plan:****In the event of a community-wide disaster, (e.g., flood, tornado, blizzard), I will (describe plan):** |
| **Additional Case Notes:**  |

**Choosing Community Long Term Care**

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| **[ ]  Yes** **[ ]  No I have been offered a choice between receiving services in the community or in the Nursing Home.****[ ]  Yes [ ]  No I have been given a choice of different types of services that can meet my needs, as seen on my plan.****[ ]  Yes** **[ ]  No I have been offered a choice of providers from available providers.****[ ]  Yes [ ]  No I have annually received my appeal rights.****[ ]  Yes [ ]  No I am aware that healthcare information about me will be kept private. (Data Privacy rights)****[ ]  Yes** **[ ]  No I have discussed my plan of care with my Care Coordinator/Case Manager and have chosen the services I want.****[ ]  Yes** **[ ]  No I agree with the plan of care as discussed with my Care Coordinator/Case Manager.** |
|  |
| **[ ]  I CHOOSE TO SHARE CARE PLAN INFORMATION WITH THE FOLLOWING HOME AND COMMUNITY BASED SERVICES (HCBS) PROVIDERS (EW/HSS)** |
|  **Provider 1** **[ ]  Complete Care Plan** **[ ]  Care Plan Summary Letter** **[ ]  None** |
|  **Provider 2** **[ ]  Complete Care Plan [ ]  Care Plan Summary Letter [ ]  None** |
|  **Provider 3** **[ ]  Complete Care Plan [ ]  Care Plan Summary Letter [ ]  None** |
|  **Provider 4** **[ ]  Complete Care Plan [ ]  Care Plan Summary Letter [ ]  None** |
|  **Provider 5** **[ ]  Complete Care Plan [ ]  Care Plan Summary Letter [ ]  None** |
| (NOTE: Not an option for HSS)**[ ]  I CHOOSE NOT TO SHARE MY CARE PLAN WITH ANY EW SERVICE PROVIDERS**  |
|  |
| **MY/MY REPRESENTATIVE SIGNATURE:** | **DATE:**  |
| **CARE COORDINATOR/CASE MANAGER SIGNATURE:** | **DATE:** |
| **CARE PLAN MAILED/GIVEN TO ME ON:** | **DATE:** |
| **CARE PLAN OR SUMMARY MAILED/GIVEN TO MY DOCTOR (verbal, phone, fax, EMR):**  | **DATE:** |

**Name:** **Health Plan I.D.Number:**

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| **HOME AND COMMUNITY BASED SERVICE AND SUPPORT PLAN/BUDGET WORKSHEET** |
| **Services offered, if appropriate.** Mark “X” if service was offered. If member accepts, fill in applicable sections below for each formal or informal provider. |
| [ ]  Adult Day Care Bath | [ ]  Help w/ MA, Finances, other paperwork | [ ]  PCA Supervision |
| [ ]  Adult Day Services | [ ]  Homemaking | [ ]  Personal Emergency Response System (PERS) |
| [ ]  Customized Living | [ ]  Home Modifications | [ ]  Respite |
| [ ]  24-hour Customized Living | [ ]  Home Delivered Meals | [ ]  Therapies at home: PT, OT, ST |
| [ ]  Care Coordination/Case Management | [ ]  Home Health Aide | [ ]  Transportation |
| [ ]  Care Coordination Para Professional | [ ]  Housing Stabilization Services (HSS) | [ ]  Yardwork/Chores |
| [ ]  Caregiver Support  | [ ]  Individual Community Living Support (ICLS) | [ ]  CDCS FSM:      Support Planner:       |
| [ ]  Companion Services | [ ]  Nurse Visits | [ ]  Supplies and Equipment |
| [ ]  Foster Care | [ ]  Personal Care Assistant (PCA) |  |
| **Formal/paid services authorized:** |
| **Provider Name** | **Service Provided** | **Schedule/Frequency** | **Start Date/End Date** | **Total Cost per Month** |
|       |  |       |       |       |
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| Case Mix Level:      | CAP Amount:      | Member Waiver Obligation if known:      | Total Cost of Authorized Services:      | Customized Living Verification Code (if applicable):       | Notes:      |
| **Informal, non-paid community supports or resources (i.e., caregiver, neighbor, volunteer):** |
| **Informal Provider** | **Service Provided** | **Schedule/Frequency** |
|       |       |       |
|       |       |       |
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| **Additional comments, if applicable:**      |