

**AccessAbility Solution ®/ AccessAbility Solution Enhanced®**

**Special Needs Basic Care (SNBC)**

**MEMBER CARE PLAN**

**Information about me**

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| Name:       | **Health Plan ID Number:**  | **Care Plan Completion Date:** |
| **Phone #:** | **Product:** Choose an item. | **Product Enrollment Date:** |
| **My Address:** | **DOB:** | **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 [ ]  No****If no, reason:** | **Primary language is:****[ ]  English [ ] Hmong [ ]  Spanish****[ ]  Somali [ ]  Vietnamese [ ] Russian****[ ]  Other (*Type in the “other” language*)****Interpreter Needed: [ ]  Yes [ ]  No****Name and number of Interpreter (*If applicable*):**  |

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

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| **Care Coordinator/Case Manager:****Name:****Phone #:** | **Primary Physician:** **Phone #:****Fax #:** | **Clinic:** |
| **If applicable: County waiver worker name/contact:** | **If applicable: County waiver program****[ ]  CAC [ ] CADI [ ] BI (TBI) [ ]  DD** |
| **Emergency Contact Name & Phone:** | **Power of Attorney/Guardian Name & Phone:** |
| **Mental Health Targeted Case Manager: [ ]  Yes [ ] No****Name of MHTCM:** **Phone Number of MHTCM:** |
| **Other Care Team Members Name** | **Relationship** | **Phone Number** |
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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:** |

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| **Caregiver listed on HRA: *(Caregivers are unpaid person(s) providing services; if there was no caregiver, the service would have to be purchased.)*****[ ]  Yes [ ]  No****If Yes, how was the caregiver assessment form completed?****[ ]  Declined [ ]  Face-to-Face [ ]  Telephone [ ]  Mail Date Completed:** |

**Care Plan Completion**

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| **SIGNATURE OF CARE COORDINATOR COMPLETING THIS PLAN:** | **DATE:** |
| **CARE PLAN MAILED/GIVEN TO MEMBER** | **DATE:** |
| **CARE PLAN OR SUMMARY MAILED/GIVEN TO PCP****(verbal, phone, fax)**  | **DATE:** |
| **Communication with Waiver Worker attempted, if applicable** | **DATE:** |

**Managing and Improving My Health**

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| **CONDITION/SCREENING** | **An educational conversation must take place with client on applicable topics. If member needs are identified a goal should be created unless member declines.** |
|  | **Check if educational conversation took place** | **Check if Goal Needed** | **Check if N/A, Contraindicated, Declined** | **Notes** |
| **PREVENTIVE HEALTH** |
| **Annual Preventive Health Exam**  |  |  |  |  |
| **Breast Cancer Screening (women 40+ at PCP recommendation depending on risk factors)** |  |  |  |  |
| **Child and Teen Checkup (up to age 21)** |  |  |  |  |
| **Colorectal Screening****(Men and Women 50+ or earlier depending on risk factors)** |  |  |  |  |
| **Dental Exam**  |  |  |  |  |
| **Flu shot *(Annually)*** |  |  |  |  |
| **Hearing Exam**  |  |  |  |  |
| **Pneumovax (*Immunize those at high risk once, and again after 5ys)*** |  |  |  |  |
| **Tetanus Booster (As needed and once every 10 years)** |  |  |  |  |
| **Vision Exam**  |  |  |  |  |
| **OTHER HEALTH EDUCATION** |
| **Blood Pressure:****(Blood Pressure Goal is <140/80 to age 75)** |  |  |  |  |
| **Cholesterol check (all ages as directed by PCP)** |  |  |  |  |
| **Continence needs (Evaluated by a physician)** |  |  |  |  |
| **Diabetic routine checks as recommended by physician (Discuss with care team: Hypertension, Neuropathy, Eye exam, Cholesterol, A1C)** |  |  |  |  |
| **Medication Compliant?** | **[ ]  Yes [ ]  No (If not compliant with medications please create a goal).** |
| **Safe Disposal of Medication Discussion** | I have discussed safe disposal of medications and was provided supporting documents.[ ]  Yes [ ]  N/A Comments:       |
| **Risk for Falls (Afraid of falling, has fallen in the past).** |  |  |  |  |
| **Other Assessed Needs** | **Discuss and provide education about any of the following assessed needs.**  |
| **Education/Employment** |  |  |  |  |
| **Family Planning** |  |  |  |  |
| **Housing** |  |  |  |  |
| **Rehabilitative Services** |  |  |  |  |
| **Transportation** |  |  |  |  |
| **Other:**  |  |  |  |  |
| **Other:**  |  |  |  |  |
| **Other/Notes:**  |
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| **Behavioral Health/Substance Use Diagnosis (If applicable):**       [ ]  N/A | Managed by a Health Professional? [ ]  Yes [ ]  No(Psychiatrist, Psychologist, Primary Care Physician)Need Goal? [ ]  Yes [ ]  No [ ]  Declined (If goal needed, document in member goals section)Notes: |
| **Disease Management/Complex Case Management Referral** | **[ ]** Yes [ ] No Diagnosis/Notes: |

1. **My Goals (Issues, needs, and all areas of concern identified on the HRA must be addressed in the Care Plan)**

| **My Goals** | **Intervention/Supports Needed** | **Target Date** | **Monitoring Progress/Goal Revision date** | **Date Goal Achieved /Not Achieved (Month/Year)** |
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**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**

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| **Follow-up Plan:****[ ]  Contact Once a Month for 3 Months****[ ]  Contact 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 need help finding alternative housing
* I need help coordinating with my waiver case manager
* I can no longer do some things that I had been able to do by myself (such as meal preparation, bathing, bill paying)
* I need help finding a behavioral health provider or health care 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
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| **Emergency Plan:****As discussed with patient and/or family, in the event of an emergency member will: (check all that apply)****[ ]  Call 911** **[ ]  Call Emergency Contact****[ ]  Call Other Informal Support Person Name:** **Phone:** **[ ]  Other (describe)** **Self Preservation/Evacuation Plan:****If member is unable to evacuate independently in an emergency, describe evacuation plan:** **If other self-preservation concerns or plans, describe:**  |
| **Essential Services Backup Plan: (*when providers of essential services are unavailable)*****Member is receiving essential services [ ]  Yes [ ]  No****If Yes, briefly describe member’s backup plan:**  |
| **Community-Wide Emergency Plan:****In the event of a community-wide disaster, (e.g., public health emergency, flood, tornado, blizzard), I will (describe plan):** |
| **Additional Case Notes:**  |

1. **Medica AccessAbility Solution® /** **Medica AccessAbility Solution Enhanced® SNBC Service Plan**

**Please include ALL services, i.e. skilled home care, custodial home care, home-and-community-based services, medical supplies, etc. This will include services being provided/paid for by other sources (waiver programs, informal supports, etc.)**

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| **Provider Name** | **Service/Support Provided** | **Payment Type** | **Schedule/Frequency** | **Start Date/End Date** |
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| **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:**      |