MSHO/ISNBC UNABLE TO CONTACT/ REFUSAL CARE PLAN

Member Name:		Today's Date:	
Member DOB:		Health Plan ID #:	
Care Coordinator Name		Member Phone:	
Care Coordinator Phone:		Assessment Type:	Select One

Care Coordinator Interventions: Member

Care Coordinator (CC) will attempt to contact member a minimum of annually or based on reporting, change in condition or admission to facility.

Outcome:

☐ Unable to contact member either by telephone or mail:
Attempt #1 –
Attempt #2 –
Attempt #3 –
Date of on-going No Contact Letter:

☐ No valid member contact information is available. Document below what resources were used to try and locate contact information (see p. 2 for suggested resources).

☐ Member not responding to calls or correspondence

☐ Other:

☐ Member declines Health Risk Assessment Date of Refusal: Date of Refusal Letter:

Refusal discussion was with: ☐ Member ☐ Member's Authorized Representative ☐ Other (please specify):

Document refusal conversation with member or person authorized to speak on member's behalf here:

☐ CC will send Member Engagement Questionnaire (Required) Date Sent:

☐ CC will send Medica Leave Behind Document (Required) Date Sent:

Care Coordinator Interventions: Primary Care Physician (PCP)

Physician Name: Physician Phone #:

PCP information obtained from: Select One

Other sources used or reviewed:

☐ CC communicated with PCP (when PCP known)

Method of PCP Communication: Select One Date of PCP communication:

If Communication Method = "Other," please specify:

Goal(s)

☐ To offer a health risk assessment and care coordination support at least annually according to DHS, CMS and Medica guidelines.

☐ Other:

☐ Other:

☐ Other:

Suggested resources to locate member contact information (note: only phone calls to members are considered an outreach attempt)

- County Financial Worker
- Waiver Worker
- Primary Care Physician
- Primary Care Clinic
- Pharmacy
- Providers (Homecare, PCA, DME companies)
- Provide A Ride/QRyde
- MMIS Restricted Recipient Program
- MNITS Internet search

Ongoing Monitoring/Outcomes/Dates Goal(s) Achieved

Monitoring/Comments

Outcomes/Dates Goal(s) Achieved

Care Plan reviewed/updated:

Care Coordinator Signature: **Date:**

Care Coordinator Name & Credentials (printed or typed):