**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  No  If 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)**

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| --- | --- | --- | --- | --- |
| **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  No  If 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 D  Rx for Ca Vitamin D?  (as directed by physician) |  |  |  |  |
| Aspirin  Rx 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:** | | | | | | | | | | | |