My Care Plan and Community Support Plan

Information About Me

Name:	**My Health Plan ID Number:**	**My Health Plan Name:**	**Care Plan Completion 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)

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

What's Important to Me? ***(e.g., living close to my family, visiting friends)***

Initial/Annual:
Update:

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

Initial/Annual:
Update:

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

Initial/Annual:
Update:

Caregiver:

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

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.**			

Safe Disposal Discussion	**I have discussed safe disposal of medications and provided supporting documents?** ☐ **Yes** ☐ **N/A** **Comments:**
List of Medications ***(If not on LTCC)***	
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)***	

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.

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					

Barriers to meeting my goals

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

My safety concerns were discussed with my Care Coordinator: ☐ **Yes**

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

☐ **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 SERVICE (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**

☐ **I CHOOSE NOT TO SHARE MY CARE PLAN WITH ANY HCBS SERVICE PROVIDERS** (note: not an option for HSS)

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:**

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 FSE: 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
	Select Service			
	Select Service			
	Select Service			
	Select Service			
	Select Service			
	Select Service			
	Select Service			
	Select Service			

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	

Additional comments, if applicable:

Toll free 1-800-203-7225, TTY 1-800-688-2534

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တကွၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစီနီၢ်ဂ့ၢ်လၢထးအံၤနူဉ်တကွၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. UCare does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Toll Free: 1-800-203-7225
TTY: 1-800-688-2534
Fax: 612-884-2021
Email: cag@ucare.org

Auxiliary Aids and Services: UCare provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Language Assistance Services: UCare provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the OCR directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll-free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service