



All UCare Products Institutional Care Coordination Documentation

Initial Annual 6 month Other Product: MSHO MSC+

Member Name:	Visit Date:
Member ID#:	DOB:
Facility:	Facility Phone:
County:	Primary Care Clinic:
SNF Admission Date:	Doctor:
Enrollment / Transfer Date:	Doctor Phone #:

MEMBER CHART REVIEW SECTION

Primary/Authorized Representative Contact Information

Name:

Relationship status: (son, daughter, POA guardian, etc):

Address:

Phone:

Health Care Directive or Living Will on file? Yes No

If no, discussed or provided info?

If not discussed, why?

Health Care Agent Name:

Hospital / ER Visits past year dates:

Notes:

Reviewed Minimum Data Set (MDS) or other current comprehensive health assessment

Date of Last MDS: (Attach ICT list in members file or list team members below)

Notes:

Reviewed cognitive status

Notes:

Reviewed mood status

Notes:

Current Rehab Therapies / Skilled Services (OT, PT, ST)

Notes:

Annual Preventative Measures

Review of most recent MD or NP nursing home visit and/or annual PCP visit. Date of visit:

Notes:

Preventative health measures discussed at visit.

Diagnosis:

Medications:

Immunizations: Flu Pneumonia Shingles Tdap Other:

Ancillary Care Providers seen in the last year as appropriate:

Podiatry Dental Vision Audiology Psychiatry Other:

Notes:

Comprehensive Plan of Care Reviewed:

Multi-Disciplinary	Holistic	Preventive in Focus	Member/Family Participation
Psychosocial	Behavioral	Environmental	Nutritional Concerns/Wt loss or gain
Pain Management	Skin Integrity	Utilizes Facility Services	Member/Family
Reviewed Care Plan Goals	Reviewed barriers to goals (if any)		ADL's/IADL's

Notes:

Level of Care Appropriate: Yes No

If no, alternative services Home and Community Based Services (HCBS) addressed.

Is the member able to or wish to move back to the community? Yes No

Notes:

Nursing home plan of care attached in members file: Yes No **Date:**

MEMBER AND/OR COLLABORATIVE CONTACTS SECTION

Met with member, reviewed Care Coordinator Role, addressed member concerns (if any) Date:

Notes:

Met family or authorized representative Date:

Notes:

Discussed TOC Date:

Notes:

MEMBERS OF THE ICT

DISCUSSION WITH FACILITY STAFF

Name: Discipline: Date:

Name: Discipline: Date:

Updates/General Notes

Care Coordinator: Date:
Delegated Entity/Agency: