**UCare I-SNP Individualized Plan of Care (IPOC)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Member Name:** |  | **Member DOB:** |  |
| **Member Phone #:** |  | **Marital Status:** |  |
| **Address:** |  | **Name of Facility:** |  |
| **Primary Language:** |  | **Interpreter Needed?** | [ ]  Yes [ ]  NoName and number of Interpreter (if applicable): Click or tap here to enter text. |
| **Sources of Information for Plan of Care:** |  | **UCare ID #:** |  |
| **ISNP Enrollment Date:** |  | **Completion Date of the Provider Comprehensive Assessment:** |  |
| **Completion Date of the HRA:** |  | **Completion Date of this IPOC:** |  |
| **IPOC visit type** | [ ]  In Person[ ]  Real-time interactive Telehealth |  |  |

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

|  |  |  |
| --- | --- | --- |
| **Care Coordinator and Credentials:** **Delegate Organization:****Phone #:**  | **Primary Physician:** **Phone #:** **Fax #:**  | **Clinic:** |
| **Facility Contact:****Phone:****Fax:** | **My Designated Representative is:****Relationship:****Phone:** |
| **Other Care Team Member’s Name** | **Relationship to me** | **Phone** |
|  |  |  |
|  |  |  |
|  |  |  |

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

|  |
| --- |
| Initial/Annual:       |
| Update:       |

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

|  |
| --- |
| Initial/Annual:      |
| Update:       |

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

|  |
| --- |
| Initial/Annual:       |
| Update:       |

**My Health:**

|  |  |
| --- | --- |
| **My Medications:** | I need help with my medications?[ ]  Yes [ ]  No[ ]  N/A (no medications used)Comments: Click or tap here to enter text.Care Coordinator completed a medication review?[ ]  Yes [ ]  No (if no, why?) Click or tap here to enter text. |
| **My Specialized Treatments/Therapies/Diets:** |  |
| **Hospitalizations:** *(Add dates and reason as they occur)* |  |
| **ER visits:** *(Add dates and reason as they occur)* |  |

**Advanced Care Directives:**

|  |
| --- |
| **Is there an Advance Directive or Health Care Directive in place?**[ ] Yes [ ]  No |
| **Was Advance Directive/Health Care Directive reviewed/discussed:**[ ] Yes [ ]  No If no, reason:       |
| **Notes:**       |

***SDoH: Living Situation, Food & Transportation (Complete the section below based on how these questions were answered on the HRA.* \**Follow up should indicate all actions taken by the Care Coordinator if the member’s response is anything yes, always, usually or sometimes. The only time a CC is not required to take action is if the member responds, no or rarely/never.)***

|  |
| --- |
| **Initial/Annual:** Living Situation: [ ]  Yes [ ]  NoFollow up: Click or tap here to enter text. Food: [ ]  Yes [ ]  No Follow up: Click or tap here to enter text.Transportation: [ ]  Yes [ ]  NoFollow up: Click or tap here to enter text. |
| **Update:** Living Situation: Click or tap here to enter text.Food: Click or tap here to enter text.Transportation: Click or tap here to enter text.  |

**My Goals (SMART goal format required: Specific, Measurable, Attainable, Realistic and Time-bound)**

The member or member designee’s goals for life, health, safety, relationships, and community connections.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 Notes About My Goals:**

|  |
| --- |
|  |

**My Safety Plan:**

|  |
| --- |
| **Identified areas of risk to overall health:** **My plan for managing risks:**       |

**Did the member / member designee agree to Care in Place?** [ ]  **Yes** [ ]  **No**

(if no, explain)

**Individualized Care Plan Agreement and Signatures**

 I have discussed my Individualized Plan of Care (IPOC) with my Care Coordinator. [ ]  **Yes** [ ]  **No**

(If no, explain)

I agree with my Individualized Plan of Care (IPOC).[ ]  **Yes** [ ]  **No** (If no, explain)

 **Member / Member Designee Signature:**

|  |  |
| --- | --- |
|  | **DATE:**  |

 **Care Coordinator Signature:**

|  |  |
| --- | --- |
|  | **DATE:**  |

**Individualized Care Plan Sharing**

|  |  |  |  |
| --- | --- | --- | --- |
| **CARE PLAN RECIPIENT** | **METHOD** (Check box) |  | **DATE SHARED** |
| **Member or Member Designee** | [ ] Verbal/Phone [ ] Mail [ ] Email [ ] Fax [ ] Other:  |  |  |
| **Primary Care Provider** | [ ] Verbal/Phone [ ] Mail [ ] Email [ ] Fax [ ] Other: |  |  |
| **Facility Staff** | [ ] Verbal/Phone [ ] Mail [ ] Email [ ] Fax [ ] Other: |  |  |
| **Specialist:**  | [ ] Verbal/Phone [ ] Mail [ ] Email [ ] Fax [ ] Other: |  |  |
| **Other:**  | [ ] Verbal/Phone [ ] Mail [ ] Email [ ] Fax [ ] Other: |  |  |