**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  No  Name 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  No  Follow up: Click or tap here to enter text.  Food:  Yes  No  Follow up: Click or tap here to enter text.  Transportation:  Yes  No  Follow 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: |  |  |