**Case Management Plan of Care**

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| **I. Member Information** | | |
| Member Name: | Address: | Member phone: |
| UCare #: | DOB: | Alternate phone: |
| Primary language:  English Other | Member’s authorized representative name & phone:         Not applicable | |
| Case manager: | Case manager phone: | Initial Plan of Care date: Click here to enter a date. |
| **II. Primary Care Provider Information:** | | |
| Primary care provider: | Primary care provider phone: | Primary care provider fax: |
| Primary care clinic: | Member has an Advance Directive  Yes  No Notes (if applicable) | |
| Specialty providers:        None Reported | | |
| **III Diagnosis/Conditions:** | | |
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| **IV. Medications:** | | |
| List: Medication, Dosage, Schedule: | | |
| Update as appropriate with discontinued, new or changed meds. | | |

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| **V. Personalized Case Management Plan and Goals:**  **Developed in collaboration with the member/caregiver’s needs &preferences** | | | |
| **Member’s Goal Priority (High, Med, Low)** |  |  |  |
| **Member Goal** |  |  |  |
| **Target Date for Goal** |  |  |  |
| **Achieved Date** |  |  |  |
| **Barriers to meet goal** | Assessed, none noted.  Barriers include: | Assessed, none noted.  Barriers include: | Assessed, none noted.  Barriers include: |
| **Interventions to achieve goal**  **(Resources to be utilized, including level of care & involvement by member and / or family)** |  |  |  |
| **Review Date & Progress Toward Goal** |  |  |  |
|  | | | |
| **Member’s Goal Priority (High, Med, Low)** |  |  |  |
| **Member Goal** |  |  |  |
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| **Interventions to achieve goal**  **(Resources to be utilized, including level of care & involvement by member and / or family)** |  |  |  |
| **Review Date & Progress Toward Goal** |  |  |  |

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| **VI. Additional Case Notes** | | | |
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| **VII. Plan of Care Communicated to PCP?**  Fax  Mail | | | |
| Date: Click here to enter a date. | Date: Click here to enter a date. | Date: Click here to enter a date. | Date: Click here to enter a date. |
| **VIII. Plan of Care Updated/Modified** | | | |
| Date(s) and Case Manager: | | | |