**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:** |
|       |
| **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**  |       |       |       |
| **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** |       |       |       |

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| **VI. Additional Case Notes** |
|       |
| **VII. Plan of Care Communicated to PCP?** [x]  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:       |