



MSC+/MSHO Institutional Support Plan

<input type="checkbox"/> Initial Date:	<input type="checkbox"/> Annual Date:	<input type="checkbox"/> Mid-Year Date:	<input type="checkbox"/> Other: Date:	<input type="checkbox"/> MSC+ <input type="checkbox"/> MSHO
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MEMBER INFORMATION

Member Name	DOB	Member ID	UCare Enrollment Date
Facility Name:		Facility Address:	
Facility Phone Number:			
Facility Admission Date:	Primary Contact at Facility (Name, Title, Phone):		

INTERDISCIPLINARY CARE TEAM

Care Coordinator Name: Delegate/Agency: Phone:	Primary Care Physician: Clinic: Phone: Fax:
Representative Name: Type of representation: Phone:	Alternate/Other Representative Name: Type of representation: Phone:
Facility Social Worker: Phone/Email:	List other ICT members (Name, Relationship):
List ICT member(s) who participated in the development of the Support Plan:	

SUPPORT PLAN

Rank by Priority	My Goals	Intervention	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					

Barriers to meeting my goals:

N/A, no barriers identified.

CARE COORDINATION

My Follow-up Plan & Contact

Care Coordinator follow up will occur:

- Once a month
 Every 3 months
 Every 6 months
 Other:

Purpose of Care Coordinator Contact:

I can contact my Care Coordinator to help me with my medical, social, or everyday needs. I should contact my Care Coordinator when:

- Changes happen with my health
- I have a scheduled procedure or surgery, or I am hospitalized
- I need help finding a specialist
- I need help learning about my medications
- I would like information to help myself and my family make health care decisions
- I would like changes to my care plan or my services and supports
- I would like to talk about other service options that can meet my needs
- I am dissatisfied with one or more of my providers

Care Coordinator met with member, reviewed Care Coordinator role, addressed member concerns: Yes No

Date:

Notes:

If no, explain:

Care Coordinator met with family or representative: Yes No Not applicable

Date:

Notes:

Care Coordinator and Credentials:

Delegated Entity/Agency:

Date:

Mid-Year and Ongoing Contact Notes:

My Signature

Yes No I have been given a choice of different types of services that can meet my needs, as seen on my plan.

Yes No I have been offered a choice of providers from available providers.

Yes No I have annually received my appeal rights.

Yes No I am aware that healthcare information about me will be kept private.

Yes No I have discussed my plan of care with my Care Coordinator and have chosen the services that I want.

Yes No I agree with the plan of care as discussed with my Care Coordinator.

My/My Representative Signature:

Date:

Care Coordinator Signature:

Date:

Care Plan Mailed/Given to Me on:

Date:

Care Plan Mailed/Given to My Doctor (verbal, phone, fax, EMR):

Date:

Name:

Health Plan I.D. Number: