MSC+/MSHO Institutional Support Plan

☐ Initial Date:	☐ Annual Date:	☐ Mid-Year Date:	☐ Other: Date:	☐ MSC+ ☐ MSHO

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: