**MSC+/MSHO Institutional Support Plan**

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| [ ]  InitialDate:       | [ ]  AnnualDate:       | [ ]  Mid-YearDate:       | [ ]  Other: Date:       | [ ] MSC+ [ ] MSHO |
| **MEMBER INFORMATION** |
| Member Name      | DOB      | Member ID      | UCare Enrollment Date      |
| Facility Name      | Facility Phone Number      | Facility Address      |
| 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:      |

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| **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 |       |       |       |       |       |
| 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 [ ] NoDate:      Notes:       If no, explain:       |
| Care Coordinator met with family or representative: [ ] Yes [ ] No [ ] Not applicableDate:      Notes:       |
| Care Coordinator and Credentials:      Delegated Entity/Agency:      Date:       |
| Mid-Year and Ongoing Contact Notes:      |

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| 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: