**MSC+/MSHO Institutional Support Plan**

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| Initial  Date: | Annual  Date: | Mid-Year  Date: | | 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 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: | | | | | |

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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: