

Date

Member Name

Address

City, State, ZIP

Dear Member Name:

At UCare, we’re dedicated to improving your health and wellness. Enclosed is the Care Plan developed with you on date.

Please review this Care Plan carefully. If you find it acceptable, please sign it and return the signature page in the enclosed self-addressed, stamped envelope.

**As a reminder, during your visit we talked about:**

* Ways to manage your physical and mental health
* Using health care to maintain and improve your health
* Your preventive care needs

**Remember to contact your care coordinator if you:**

* Are hospitalized, or plan to be hospitalized
* Have a fall
* Have a change in your physical or mental health
* Need help finding supports or services

If you have questions, or don’t agree with your Care Plan, call me at phone number. You can also call if your needs change. TTY machine users please call the Minnesota Relay at 711 or 1-877-627-3848 (speech-to-speech relay service).

Thank you,

Care Coordinator Name

Care Coordinator Job Title

County or Agency Name

Phone Number

Email Address

500 Stinson Blvd NE, Minneapolis, MN 55413 | 612-676-6500 | fax 612-676-6501 | **ucare.org**

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