REFUSAL CARE PLAN

Date Refusal Care Plan Initiated:			
Member Name (Last, First)	**Member ID#**	**DOB**	**Member Phone #**
Case Manager Name & Phone #	**PCP Name**		**PCP Phone #**

Problem

☐ (Member's Name) has opted out of (does not wish to participate in) a face to face assessment even after complete explanation of program and process by care coordinator.

Goal(s)

☐ (Member's Name) will be offered a face to face assessment with UCare at least every 6 months.

Date to be re-assessed:

Barrier(s)

☐ (Member's Name) does not understand the benefits of, or denies the need for a face to face assessment even after complete explanation of the benefits by care coordinator.

☐ (Member's Name) has opted to not to participate in a face to face assessment at this time.

Intervention

☐ Provide the member with the necessary information name, telephone and fax number (i.e. letter sent) to contact the care coordinator in the event that the member decides to participate in the face to face assessment.

☐ Check if completed. Date Completed: _____

☐ Follow up call to member every six months to offer an assessment and to check the member's health status.

☐ Check if completed. Date Completed: _____

☐ Refusal LTC entered into MMIS annually.

☐ Check if completed. Date Completed: _____

Essential Services Back-up Plan: (when providers of essential services are unavailable)

Member is receiving essential services ☐ Yes ☐ NO

If Yes, briefly describe the member's backup plan:

Signature of care coordinator Date: _____