REFUSAL SUPPORT PLAN
MSHO/MSC+/SNBC

MEMBER INFORMATION	DATE REFUSAL SUPPORT PLAN COMPLETED:		
Member Name	**Member ID#**	**Date of Birth**	**Member Phone #**
Care Coordinator Name & Phone #	**Primary Care Physician Name/Clinic**		**Primary Care Physician Phone #**

CARE TEAM INFORMATION

Name	Relationship to Member	Phone #
Name	Relationship to Member	Phone #
Name	Relationship to Member	Phone #
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Has Preventive Care been addressed? ☐ Yes ☐ No
(e.g. immunizations, tobacco and alcohol use, fall risk, medication and nutrition)

If no, explain areas that need to be addressed:

Does member need help coordinating a visit for Primary and Preventive Care? ☐ Yes ☐ No ☐ NA

REFUSAL SUPPORT PLAN CONTINUED

Rank by Priority	My Goals	Intervention	Target Date	Monitoring Progress/Goal Revision Date	Date Goal Achieved/Not Achieved (Month/Year)
☐ **Low** ☐ **Medium** ☒ **High**	I will contact my Care Coordinator when I need assistance obtaining care or services over the next year.	Care Coordinator provided contact information including name and phone number.			
☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					

Care Coordinator/ Case Manager follow-up will occur:

☐ Once a month ☐ Every 3 months ☐ Every 6 months ☐ Other:

Other concerns or barriers to care:

Refusal entered into MMIS annually Date Completed:

Care Coordinator Signature: Credentials Date:

Confirm Primary Care Provider:

Date the Refusal letter sent to member:

Date Provider Engagement letter sent:

☐ Fax ☐ Email ☐ EMR ☐ N/A * N/A can be used if unable to confirm PCP