 **REFUSAL SUPPORT PLAN**

 **MSHO/Connect + Medicare**

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| **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 #      Name      Relationship to Member       Phone #       |
|  |
| 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:       |
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| Does member need help coordinating a visit for Primary and Preventive Care? [ ]  Yes [ ]  No [ ]  NA       |
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**REFUSAL SUPPORT PLAN CONTINUED**

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| Rank by Priority | My Goals | Intervention | Target Date | Monitoring Progress/Goal Revision Date | Date Goal Achieved/Not Achieved (Month/Year) |
| [ ]  **Low**[ ]  **Medium****[x]  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** |       |       |       |       |       |
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| Care Coordinator/ Case Manager follow-up will occur:  [ ]  Once a month [ ]  Every 3 months [ ]  Every 6 months [ ]  Other:      Other concerns or barriers to care:       |
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| 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 |
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