 **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: | | | | | |
|  | | | | | |
| 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**  **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 | | | | | |
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