** UNABLE TO REACH SUPPORT PLAN**

**MSHO/Connect + Medicare**

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| **MEMBER INFORMATION** | | **DATE UNABLE TO REACH SUPPORT PLAN COMPLETED:** | | | | | | | |  |
| **Member Name** | | | | **Member ID#** | | **Date of Birth** | | **Member Phone #** | | |
| **Care Coordinator Name & Phone #** | | | | **PCP Name/Clinic** | | | | **PCP Phone #** | | |
| **CARE TEAM INFORMATION** | | | | | | | | | | |
| Name      Relationship to Member       Phone #  Name      Relationship to Member       Phone #  Name      Relationship to Member       Phone #  Name      Relationship to Member       Phone # | | | | | | | | | | |
| **OUTREACH ATTEMPTS** | | | | | | | | | | |
| Outreach made by telephone or by mail please specify unable to reach attempts  Dates Attempted: #1­­­­       #2 ­­­­­­­­      #3 ­­­­­­­­      #4  Notes: | | | | | | | | | | |
| 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** |  | |  | |  | |  | |  | |

**UNABLE–TO– REACH SUPPORT PLAN CONTINUED**

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| **OUTREACH INVESTIGATION** |
| Contacted Financial Worker to obtain correct contact information, document the new information in the  member’s case file.  Check if completed. Date Completed:  Call Primary Care Physician’s office to obtain correct contact information for the member, document the  new information in the member’s case file.  Check if completed. Date Completed:  Call UCare to obtain any new contact information and/or review claims information for the member,  document the new information in the member’s case file.  Check if completed. Date Completed: |
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| Care Coordinator/ Case Manager follow-up will occur:  Once a month  Every 3 months  Every 6 months  Other:  Additional Comments: |
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| Unable to reach entered into MMIS annually Date Completed:  Care Coordinator Signature:       Credentials       Date:  Confirm Primary Care Provider:  Date Provider Engagement letter sent:  Fax  Email  EMR  N/A\* N/A can be used if unable to confirm PCP |
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