** 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 attemptsDates 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****[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** |       |       |       |       |       |

**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 themember’s case file.  [ ]  Check if completed. Date Completed:      Call Primary Care Physician’s office to obtain correct contact information for the member, document thenew 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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