

<Date>

<Member Name>

<Address>

<City, State, ZIP>

Dear <Member Name>,

At UCare, we’re dedicated to improving your health and wellness. Enclosed is the Support Plan developed with you on Date.

Please review this Support Plan carefully. If you find it acceptable, please sign it and return the signature page in the enclosed self-addressed, stamped envelope.

**As a reminder, during your visit we talked about:**

* Ways to manage your physical and mental health
* Using health care to maintain and improve your health
* Your preventive care needs
* Topic(s) discussed at visit

**Remember to contact your care coordinator if you:**

* Are hospitalized or plan to be hospitalized
* Have a fall
* Have a change in your physical or mental health
* Need help finding supports or services

If you have questions or don’t agree with your Support Plan, call me at Phone Number. You can also call if your needs change. TTY machine users please call the Minnesota Relay at 711 or 1-877-627-3848 (speech-to-speech relay service).

Thank you,

<Care Coordinator Name>

<Care Coordinator Job Title>

<County or Agency Name>

<Phone Number>

<Email Address>

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