My Connect/Connect + Medicare Support Plan

Information About Me:

Name:	My Health Plan ID Number:	My Health Plan Name:	Today's Date:
Phone #:	My DOB:	Product Enrollment Date:	My Waiver Type (if applicable):
My Address:			
My Primary Health or Mental Health Diagnosis:			

My primary language is:

☐ **English** ☐ **Hmong** ☐ **Spanish** ☐ **Somali** ☐ **Vietnamese** ☐ **Russian** ☐ **Other (*Type in the "other" language*):**

I need an interpreter:

☐ **Yes** ☐ **No**

Name: **Phone:**

My Care Team (Interdisciplinary Care Team-ICT):

UCare Care Coordinator/Case Manager: Name: Phone #:	Primary Care Provider (PCP): Phone #: Fax #:	PCP Clinic:

My Representative is (if applicable):
Name:

Phone:

They can be contacted for:

I have a Mental Health Targeted Case Manager:

☐ **Yes** ☐ **No**

Name: **Phone Number:**

Is My Mental Health Managed by a Health Professional (Psychiatrist, Psychologist, Primary Care Physician)?

☐ **Yes** ☐ **No**

Need Goal? ☐ **Yes** ☐ **No** ☐ **Declined**

Waiver Case Manager (if applicable):

Name:

Phone Number:

Other Medical Care Team Members Name	Relationship to me	Give Copy of Support Plan?	Date sent

What's Important to Me? *(e.g. living close to my family, visiting friends)*

Initial/Annual:

Update:

My Strengths: *(e.g. skills, talents, interests, information about me)*

Initial/Annual:

Update:

My Supports and Services: *(What do I want help with? Service and support I requested? From whom?)*

Initial/Annual:

Update:

Managing and Improving My Health

Screening for my health				
	Check if educational conversation took place with me	**Goal is needed**	**Check if N/A, contraindicated, declined**	**Notes**
Annual Preventive Health Exam	☐	☐	☐	
Mammogram	☐	☐	☐	
Colorectal Cancer Screening	☐	☐	☐	
At Risk for Falls (Afraid of falling, has fallen in the past)	☐	☐	☐	
Flu shot	☐	☐	☐	
Tetanus Booster *(Once every 10 years)*	☐	☐	☐	
Hearing Exam	☐	☐	☐	
Vision Exam	☐	☐	☐	
Dental Exam	☐	☐	☐	
Aspirin Rx for Aspirin? (as directed by physician)	☐	☐	☐	
Blood Pressure	☐	☐	☐	
Cholesterol check	☐	☐	☐	

Diabetic routine checks as recommended by physician: Hypertension → Nephropathy → Diabetic Eye exam → Cholesterol → A1C →	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	
Other:	☐	☐	☐	
My Medications	**I need help with my medications?** ☐ **Yes** ☐ **No** ☐ **N/A (no medications used)** **If yes, create a goal.**			
Safe Disposal of Medication Discussion	**I have discussed safe disposal of medications and was provided supporting documents.** ☐ **Yes** ☐ **N/A** **Comments:**			
Health Improvement Referral	☐ **Yes** ☐ **Declined** ☐ **N/A** **Diagnosis:**			

My Goals: *Discuss with Care Coordinator, goals for: my everyday life (taking care of myself or my home); my relationships and community connections; my future plans, my health, my safety; my choices.*

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					

Barriers to meeting my goals: ☐ No barriers identified

Initial/Annual:

Update:

My follow up plan:

Care Coordinator/Case Manager follow-up will occur:

- ☐ **Every 3 months**
- ☐ **Every 6 months**
- ☐ **Other (Please specify):**

I can contact my Care Coordinator to help me with my medical, social or everyday needs. I should contact my Care Coordinator when:

- **Changes happen with my health**
- **I have a scheduled procedure or surgery or I am hospitalized**
- **I have experienced falls in my home or community**
- **I can no longer do some things that I had been able to do by myself (such as meal preparation, bathing, bill paying)**
- **If I need additional community services such as: equipment for bathroom safety or home safety; information about topics such as staying healthy, preventing falls, immunizations, etc.**
- **I need help finding a specialist**
- **I need help learning about my medications**
- **I would like information to help myself and my family make health care decisions**
- **I would like changes to my care plan or my services and supports**
- **I would like to talk about other service options that can meet my needs**
- **I am dissatisfied with one or more of my providers**

My Safety Plan:

My safety concerns were discussed with my Care Coordinator: ☐ **Yes** ☐ **No**

My plan for managing risks that I have discussed with my Care Coordinator is:

Emergency Plan:

In the event of an emergency, I will (check all that apply):

- ☐ **Call 911**
- ☐ **Use Emergency Response Monitoring System**
- ☐ **Call Emergency Contact**
- ☐ **Call Other Person Name: Phone:**
- ☐ **Other (describe):**

Self-Preservation/Evacuation Plan:

If I am unable to evacuate on my own in an emergency, my plan is to:

If other concerns or plans, describe:

Essential Services Backup Plan: (*when providers of essential services are unavailable; essential services are services that if not received, health and safety would be at risk)*

I am receiving essential services: ☐ **Yes** ☐ **No**

Essential services I am receiving:

If Yes, describe provider's backup plan, as agreed to by me:

HOME AND COMMUNITY BASED SERVICES

My Current Services: Mark "X" if service(s) are currently being used.		
☐ Adult Day Services	☐ Help w/ MA, Finances, other paperwork	☐ Personal Emergency Response System (PERS)
☐ Customized Living	☐ Homemaking	☐ Respite
☐ 24-hour Customized Living	☐ Home Modifications	☐ Therapies at home: PT, OT, ST
☐ Care Coordination/Case Management	☐ Home Delivered Meals	☐ Transportation
☐ Caregiver Support	☐ Individual Community Living Support (ICLS)	☐ Yard work/Chores
☐ Companion Services	☐ Nurse Visits	☐ Foster Care
☐ Personal Care Assistant (PCA)	☐ Home Health Aide	☐ Supplies and Equipment
☐ PCA Supervision	☐ ARMHS	☐ ILS
☐ Other:	☐ Other:	☐ Other:

My HCBS (Not PCP, Specialty Providers, or others listed in ICT) Contact Information:

Provider Name & Phone #	Service Provided	Schedule/Frequency	Start Date/End Date
	Select Service item Select		
	Select Service item Select		
	Select Service item Select		
	Select Service item Select		

Informal, non-paid community supports or resources (i.e., caregiver, family, neighbor, volunteer):		
Informal Provider/Contact #	**Service Provided**	**Schedule/Frequency**

Additional comments, if applicable:

Signature Page: PLEASE ENTER CREDENTIALS WITH SIGNATURE

MY/MY REPRESENTATIVE SIGNATURE:	**DATE:**
CARE COORDINATOR/CASE MANAGER SIGNATURE AND CREDENTIALS:	**DATE:**
SUPPORT PLAN MAILED/GIVEN TO ME ON: ☐ Yes ☐ No	**DATE:**
SUPPORT PLAN MAILED/GIVEN TO MY DOCTOR (verbal, phone, fax, EMR):	**DATE:**

Name: **Health Plan I.D.Number:**

1-800-203-7225

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မိတခါအံၤန့ဉ်, ကိးဘဉ်လီတဲစိနီၢ်ဂ်ၢ်လၢထးအံၤန့ဉ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ, ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. UCare does not discriminate on the basis of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

Auxiliary Aids and Services. UCare provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner, to ensure an equal opportunity to participate in our health care programs. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Language Assistance Services. UCare provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You may contact any of the following four agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National Origin
- Age
- Disability
- Sex (including sex stereotypes and gender identity)

Contact the OCR directly to file a complaint:

Director
U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW
Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (Voice)
800-537-7697 (TDD)
Complaint Portal – *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National Origin
- Religion
- Creed
- Sex
- Sexual Orientation
- Marital Status
- Public Assistance Status
- Disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (Fax)
Info.MDHR@state.mn.us (Email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
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Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have a right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome period. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administration actions.

Contact **DHS** directly to file a discrimination complaint:

ATTN: Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

UCare Complaint Notice

You have the right to file a complaint with UCare if you believe you have been discriminated against in our health care programs because of any of the following:

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Phone: 612-676-3200
1-800-203-7225 toll free
TTY: 612-676-6810 or
1-800-688-2534 toll free
Email: cag@ucare.org
Fax: 612-884-2021

Mailing address
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052