**{UCare I-SNP Individualized Plan of Care (IPOC)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Member Name:** |  | **Member DOB:** |  |
| **Member Phone #:** |  | **Marital Status:** |  |
| **Address:** |  | **Name of Facility:** |  |
| **Primary Language:** |  | **Interpreter Needed?** | [ ]  Yes [ ]  NoName and number of Interpreter (if applicable): Click or tap here to enter text. |
| **Sources of Information for Plan of Care:** |  | **UCare ID #:** |  |
| **ISNP Enrollment Date:** |  | **Completion Date of the Provider Comprehensive Assessment:** |  |
| **Completion Date of the HRA:** |  | **Completion Date of this IPOC:** |  |
| **IPOC visit type** | [ ]  In Person[ ]  Real-time interactive Telehealth |

**My Care Team (Interdisciplinary Care Team-ICT):**

|  |  |  |
| --- | --- | --- |
| **Care Coordinator and Credentials:** **Delegate Organization:****Phone #:**  | **Primary Physician:** **Phone #:** **Fax #:**  | **Clinic:** |
| **Facility Contact:****Phone:****Fax:** | **My Designated Representative is:****Relationship:****Phone:** |
| **Other Care Team Member’s Name** | **Relationship to me** | **Phone** |
|  |  |  |
|  |  |  |
|  |  |  |

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

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| --- |
| Initial/Annual:       |
| Update:       |

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

|  |
| --- |
| Initial/Annual:      |
| Update:       |

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

|  |
| --- |
| Initial/Annual:       |
| Update:       |

**My Health:**

|  |  |
| --- | --- |
| **My Medications:** | I need help with my medications?[ ]  Yes [ ]  No[ ]  N/A (no medications used)Comments: Click or tap here to enter text.Care Coordinator completed a medication review?[ ]  Yes [ ]  No (if no, why?) Click or tap here to enter text. |
| **My Specialized Treatments/Therapies/Diets:** |  |
| **Hospitalizations:** *(Add dates and reason as they occur)* |  |
| **ER visits:** *(Add dates and reason as they occur)* |  |

**Advanced Care Directives:**

|  |
| --- |
| **Is there an Advance Directive or Health Care Directive in place?**[ ] Yes [ ]  No |
| **Was Advance Directive/Health Care Directive reviewed/discussed:**[ ] Yes [ ]  No If no, reason:       |
| **Notes:**       |

**SDoH*: Based on the members responses to the SDoH questions (Living Situation, Food & Transportation) during the HRA (yes, always, usually, or sometimes, no or rarely/never), indicate below Y/N on each SDoH question if there is concern and follow up is needed. Follow up should indicate all actions taken by the Care Coordinator if the member’s response is yes, always, usually, or sometimes. The CC is not required to take action if the member responds “no” or “rarely/never.”***

|  |
| --- |
| **Initial/Annual:** Living Situation: [ ]  Yes [ ]  No Follow up: Click or tap here to enter text. Food: [ ]  Yes [ ]  No Follow up: Click or tap here to enter text.Transportation: [ ]  Yes [ ]  No Follow up: Click or tap here to enter text. |
| **Updates:** Living Situation: Click or tap here to enter text.Food: Click or tap here to enter text.Transportation: Click or tap here to enter text.  |

**My Goals (SMART goal format required: Specific, Measurable, Attainable, Realistic and Time-bound)**

The member or member designee’s goals for life, health, safety, relationships, and community connections.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Rank by Priority  | My Goals  |  Support(s) Needed | Target Date | Monitoring Progress/Goal Include revision date and updated goal outcome | Date Goal Achieved/ Not Achieved(Month/Year) and document goal outcome |
| [ ]  Low[ ]  Medium[ ]  High |       |       |       |       |       |
| [ ]  Low[ ]  Medium[ ]  High |       |       |       |       |       |
| [ ]  Low[ ]  Medium[ ]  High |       |       |       |       |       |
| [ ]  Low[ ]  Medium[ ]  High |       |       |       |       |       |

**Additional Notes About My Goals:**

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| --- |
|  |

**My Safety Plan:**

|  |
| --- |
| **Identified areas of risk to overall health:** **My plan for managing risks:**       |

**Did the member/member designee agree to Care in Place?** [ ]  **Yes** [ ]  **No**

(if no, explain)

**Individualized Care Plan Agreement and Signatures**

 I have discussed my Individualized Plan of Care (IPOC) with my Care Coordinator. [ ]  **Yes** [ ]  **No**

(If no, explain)

I agree with my Individualized Plan of Care (IPOC).[ ]  **Yes** [ ]  **No** (If no, explain)

 **Member / Member Designee Signature:**

|  |  |
| --- | --- |
|  | **DATE:**  |

 **Care Coordinator Signature and Credentials:**

|  |  |
| --- | --- |
|  | **DATE:**  |

**Individualized Care Plan Sharing**

|  |  |  |  |
| --- | --- | --- | --- |
| **CARE PLAN RECIPIENT** | **METHOD** (Check box) |  | **DATE SHARED** |
| **Member or Member Designee** | [ ] Verbal/Phone [ ] Mail [ ] Email [ ] Fax [ ] Other:  |  |  |
| **Primary Care Provider** | [ ] Verbal/Phone [ ] Mail [ ] Email [ ] Fax [ ] Other: |  |  |
| **Facility Staff** | [ ] Verbal/Phone [ ] Mail [ ] Email [ ] Fax [ ] Other: |  |  |
| **Specialist:**  | [ ] Verbal/Phone [ ] Mail [ ] Email [ ] Fax [ ] Other: |  |  |
| **Other:**  | [ ] Verbal/Phone [ ] Mail [ ] Email [ ] Fax [ ] Other: |  |  |