

**MSC+/MSHO Institutional Support Plan**

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| **MEMBER INFORMATION** | | | | | | | |
| Initial Date: | Annual Date: | | Mid-Year Date: | | Other Date: | | MSC+  MSHO |
| Member Name: | | DOB: | | Member ID: | | UCare Enrollment Date: | |

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| **FACILITY INFORMATION** | | |
| Facility Name: | Facility Phone Number: | Facility Admission Date: |
| Facility Address: | | |

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| **INTERDISCIPLINARY CARE TEAM** | |
| Care Coordinator Name:  Delegate/Agency:  Phone: | Representative Name:  Type of Representation:  Phone: |
| Primary Care Physician:  Clinic:  Phone:  Fax: | Facility Social Worker:  Phone/Email: |
| Additional ICT Members (Name, Relationship): |

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| **SUPPORT PLAN** | | | | | |
| Rank by Priority | My Goals | Intervention | Target Date | Monitoring Progress/Goal Revision Date | Date Goal Achieved/Not Achieved (Month/Year) |
| Low  Medium  High |  |  |  |  |  |
| Low  Medium  High |  |  |  |  |  |

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| Low  Medium  High |  |  |  |  |  |
| Barriers to meeting my goals:    N/A – No barriers identified. | | | | | |

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| **CARE COORDINATION** | |
| My Follow-Up Plan & Contact | |
| Care coordinator follow up will occur:  Once a month  Every 3 months  Every 6 months  Other: | |
| Purpose of care coordinator contact:  Coordination of services among different health and social service professionals and across settings of care, including the provision of all Medicaid and/or Medicare health and long-term care services as determined eligible. | |
| 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 need help finding a specialist * I need help learning about my medications * I am dissatisfied with one or more of my providers * I have a scheduled procedure or surgery, or I am hospitalized | * 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 |
| Care coordinator met with member in-person, reviewed care coordinator role, addressed member concerns: Yes No  Date:  Notes:  If no, explain: | |
| Care coordinator met with family or representative: Yes No N/A  Date:  Notes: | |
| Mid-year and ongoing contact notes: | |