

**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
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| Care coordinator met with member in-person, reviewed care coordinator role, addressed member concerns: [ ] Yes [ ] NoDate:      Notes:       If no, explain:       |
| Care coordinator met with family or representative: [ ] Yes [ ] No [ ] N/ADate:      Notes:       |
| Mid-year and ongoing contact notes:      |