



# REFUSAL SUPPORT PLAN MSHO/Connect + Medicare

MEMBER INFORMATION		DATE REFUSAL SUPPORT PLAN COMPLETED:		
Member Name		Member ID#	Date of Birth	Member Phone #
Care Coordinator Name & Phone #		Primary Care Physician Name/Clinic		Primary Care Physician Phone #

CARE TEAM INFORMATION		
Name	Relationship to Member	Phone #
Name	Relationship to Member	Phone #
Name	Relationship to Member	Phone #
Name	Relationship to Member	Phone #

Has Preventive Care been addressed?  Yes  No  
(e.g. immunizations, tobacco and alcohol use, fall risk, medication and nutrition)

If no, explain areas that need to be addressed:

Does member need help coordinating a visit for Primary and Preventive Care?  Yes  No  NA

Notes:

## REFUSAL SUPPORT PLAN CONTINUED

Rank by Priority	My Goals	Intervention	Target Date	Monitoring Progress/Goal Revision Date	Date Goal Achieved/Not Achieved (Month/Year)
<input type="checkbox"/> Low <input type="checkbox"/> Medium <input checked="" type="checkbox"/> High	I will contact my Care Coordinator when I need assistance obtaining care or services over the next year.	Care Coordinator provided contact information including name and phone number.			
<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High					
<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High					

Care Coordinator/ Case Manager follow-up will occur:

Once a month  Every 3 months  Every 6 months  Other:

Other concerns or barriers to care:

Refusal entered into MnCHOICES annually    Date member refused HRA:

Care Coordinator Signature:

Credentials:

Date:

Confirm Primary Care Provider:

Date the Refusal letter sent to member:

Date Provider Engagement letter sent:

Fax     Email     EMR     N/A    \* N/A can be used if unable to confirm PCP