

My Care Plan and Community 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 Address:	Rate Cell:	Diagnosis:	
	Date of My Assessment Visit:		
Assessment Type: <input type="checkbox"/> Initial Health Risk Assessment <input type="checkbox"/> Annual Reassessment <input type="checkbox"/> Change in My Needs <input type="checkbox"/> Other			
Is there an Advance Directive or Health Care Directive in place? Yes <input type="checkbox"/> No <input type="checkbox"/> Was Advance Directive/Health Care Directive discussed: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason:	My primary language is: <input type="checkbox"/> English <input type="checkbox"/> Hmong <input type="checkbox"/> Spanish <input type="checkbox"/> Somali <input type="checkbox"/> Vietnamese <input type="checkbox"/> Russian <input type="checkbox"/> Other (<i>Type in the "other" language</i>) I need an interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No Name and number of Interpreter (<i>If applicable</i>):		

My Care Team (Interdisciplinary Care Team-ICT)

Care Coordinator/Case Manager:	Primary Physician:	Clinic:
Name:	Phone #:	
Phone #:	Fax #:	
Emergency Contact Name & Phone:	My Representative is: They can be contacted for:	
I have a Mental Health Targeted Case Manager: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of MHTCM: Phone Number of MHTCM:		

Other Care Team Members Name	Relationship to me	Give Copy of Care plan?	Date sent

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

<p>Initial/Annual:</p>
<p>Update:</p>

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

<p>Initial/Annual:</p>
<p>Update:</p>

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

Initial/Annual:

Update:

Caregiver:

Informal Caregiver listed on HRA/LTCC: *(Caregivers are unpaid person(s) providing services)*
 Yes No
 If yes, the Caregiver Assessment Form was completed by:
 Face-to-Face Telephone Mail Declined Date Completed:

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mammogram (Within past 2 years ages 65-75)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Contenance needs (Evaluated by a physician?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colorectal Screening (Up to age 75)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
At Risk for Falls (Afraid of falling, has fallen in the past).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Pneumovax (Immunize at age 65 if not done previously. Re-immunize once if 1st pneumovax was received more than 5 years ago & before age 65)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Flu shot (Annually ages 50+ and persons at high risk.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Tetanus Booster (Once every 10 years)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hearing Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dental Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcium Vitamin D Rx for Ca Vitamin D? (as directed by physician)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin Rx for Aspirin? (as directed by physician)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Pressure: (Blood Pressure Goal is <140/80 to age 75. After 75 based on individual)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Cholesterol check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetic routine checks as recommended by physician (Discuss with my care team: Hypertension, Neuropathy, Eye exam, Cholesterol, A1C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health Diagnosis (If applicable): <input type="checkbox"/> N/A	Managed by a Health Professional? <input type="checkbox"/> Yes <input type="checkbox"/> No (Psychiatrist, Psychologist, Primary Care Physician) Need Goal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined			
My Medications	I need help with my medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (no medications used) If yes, create a goal			
List of Medications (If not on LTCC)				
Health Improvement Referral	<input type="checkbox"/> Yes <input type="checkbox"/> Declined <input type="checkbox"/> N/A Diagnosis:			
Hospitalizations (In past year number and reason, date(s) if available)				
ER visits (In past year number and reason for visit; dates, if available)				

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)
<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High					
<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High					
<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High					

<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High					
<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High					
<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High					
<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High					

Barriers to meeting my goals

Initial/Annual:
Update:
<input type="checkbox"/> No barriers identified

My follow up plan:

Care Coordinator/Case Manager follow-up will occur:

- Once a month
- Every 3 months
- Every 6 months
- Other

Purpose of Care Coordinator contact:

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; assistance with finding a new living situation (senior apartment); information about topics such as staying healthy, preventing falls, and immunizations.**
- **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

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: _____
 Other (describe)

Phone: _____

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:

Community-Wide Disaster Plan:

In the event of a community-wide disaster, (e.g., flood, tornado, blizzard), I will (describe plan):

Additional Case Notes:

Choosing Community Long Term Care

Yes No I have been offered a choice between receiving services in the community or in the Nursing Home.

Yes No I have been given a choice of different types of services that can meet my needs, as seen on my plan.

Yes No I have been offered a choice of providers from available providers.

Yes No I have annually received my appeal rights.

Yes No I am aware that healthcare information about me will be kept private.
(Data Privacy rights)

Yes No I have discussed my plan of care with my Care Coordinator/Case Manager and have chosen the services I want.

Yes No I agree with the plan of care as discussed with my Care Coordinator/Case Manager.

I CHOOSE TO SHARE CARE PLAN INFORMATION WITH THE FOLLOWING EW PROVIDERS

Provider 1

Complete Care Plan Care Plan Summary Letter None

Provider 2

Complete Care Plan Care Plan Summary Letter None

Provider 3

Complete Care Plan Care Plan Summary Letter None

Provider 4

Complete Care Plan Care Plan Summary Letter None

Provider 5

Complete Care Plan Care Plan Summary Letter None

I CHOOSE NOT TO SHARE MY CARE PLAN WITH ANY ELDERLY WAIVER SERVICE PROVIDERS

MY/MY REPRESENTATIVE SIGNATURE:

DATE:

CARE COORDINATOR/CASE MANAGER SIGNATURE:

DATE:

CARE PLAN MAILED/GIVEN TO ME ON:

DATE:

CARE PLAN OR SUMMARY MAILED/GIVEN TO MY DOCTOR
(verbal, phone, fax, EMR):

DATE:

Name:

Health Plan I.D. Number:

HOME AND COMMUNITY BASED SERVICE AND SUPPORT PLAN/BUDGET WORKSHEET

Services offered, if appropriate. Mark if service was offered. If member accepts, fill in applicable sections below for each formal or informal provider.

<input type="checkbox"/> Adult Day Care Bath	<input type="checkbox"/> Help w/ MA, Finances, other paperwork	<input type="checkbox"/> PCA Supervision
<input type="checkbox"/> Adult Day Services	<input type="checkbox"/> Homemaking	<input type="checkbox"/> Personal Emergency Response System (PERS)
<input type="checkbox"/> Customized Living	<input type="checkbox"/> Home Modifications	<input type="checkbox"/> Respite
<input type="checkbox"/> 24-hour Customized Living	<input type="checkbox"/> Home Delivered Meals	<input type="checkbox"/> Therapies at home: PT, OT, ST
<input type="checkbox"/> Care Coordination/Case Management	<input type="checkbox"/> Individual Community Living Support (ICLS)	<input type="checkbox"/> Transportation
<input type="checkbox"/> Care Coordination Para Professional	<input type="checkbox"/> Nurse Visits	<input type="checkbox"/> Yardwork/Chores
<input type="checkbox"/> Caregiver Support	<input type="checkbox"/> Home Health Aide	<input type="checkbox"/> CDCS FSE: Support Planner:
<input type="checkbox"/> Companion Services	<input type="checkbox"/> Personal Care Assistant (PCA)	<input type="checkbox"/> Supplies and Equipment
<input type="checkbox"/> Foster Care		

Formal/paid services authorized:

Provider Name	Service Provided	Schedule/Frequency	Start Date/End Date	Total Cost per Month

Case Mix Level:	CAP Amount:	Member Waiver Obligation if known:	Total Cost of Authorized Services:	Customized Living Verification Code (if applicable):	Notes:
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Informal, non-paid community supports or resources (i.e., caregiver, neighbor, volunteer):

Informal Provider	Service Provided	Schedule/Frequency

Additional comments, if applicable:

**SecureBlue 1-888-740-6013; Blue Advantage and
MinnesotaCare 1-800-711-9862; TTY 711**

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

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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. ဝဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီၤလၢတၢ်ကကျိးထံဝဲဒၣ်လံာ် တီလံာ်မိတခါအံၤန့ၣ်, ကိးဘဉ်လိတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

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

ໂປຣດຊາບ, ຖ້າທ່ານ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງໂທໂທໂປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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. Blue Plus 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. Blue Plus 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 Blue Plus at Civil.Rights.Coord@bluecrossmn.com, or call Blue Plus Member Services (651) 662-6013 (voice) or 1-888-740-6013 (toll-free) for SecureBlue or (651) 662-5545 or 1-800-711-9862 for Blue Advantage and MinnesotaCare, or your preferred relay service.

Language Assistance Services. Blue Plus 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 Blue Plus at Civil.Rights.Coord@bluecrossmn.com, or call Blue Plus Member Services (651) 662-6013 (voice) or 1-888-740-6013 (toll-free) for SecureBlue or (651) 662-5545 or 1-800-711-9862 for Blue Advantage and MinnesotaCare, or your preferred relay service.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Blue Plus. 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
- Political beliefs
- Medical condition
- Health status
- Receipt of health care services
- Claims experience
- Medical history
- Genetic information

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

Blue Cross and Blue Shield of Minnesota and Blue Plus

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of medical condition, health status, receipt of health care services, claims experience, medical history, genetic information, disability (including mental or physical impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, or public assistance, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
Blue Cross and Blue Shield of Minnesota and Blue Plus
M495
PO Box 64560
Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312 or use your preferred relay service

Grievance forms are available by contacting us at the contact listed above, by calling 10-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

American Indians: American Indians can continue or begin to use tribal and Indian Health Services (HIS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or HIS clinic refers you to a provider in our network, we will not require you to see your health plan primary care provider prior to the referral.

SecureBlueSM (HMO SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in SecureBlue depends on contract renewal.