My Care Plan and Community Support Plan

Information About Me

<table>
<tr><td>Name:</td><td>My Health Plan ID Number:</td><td>My Health Plan Name:</td><td>Today's Date:</td></tr>
<tr><td>Phone #:</td><td>My DOB:</td><td colspan="2">Product Enrollment Date:</td></tr>
<tr><td rowspan="2">My Address:</td><td>Rate Cell:</td><td colspan="2">Diagnosis:</td></tr>
<tr><td colspan="3">Date of My Assessment Visit:

Assessment Type:
☐ Initial Health Risk Assessment
☐ Annual Reassessment
☐ Change in My Needs
☐ Other</td></tr>
<tr><td>Is there an Advance Directive or Health Care Directive in place?
Yes ☐ No ☐

Was Advance Directive/Health Care Directive discussed:
☐ Yes ☐ No

If no, reason:</td><td colspan="3">My primary language is:
☐ English ☐ Hmong ☐ Spanish
☐ Somali ☐ Vietnamese ☐ Russian
☐ Other (Type in the "other" language)

I need an interpreter: ☐ Yes ☐ No

Name and number of Interpreter (If applicable):</td></tr>
</table>

My Care Team (Interdisciplinary Care Team-ICT)

<table>
<tr><td>Care Coordinator/Case Manager:
Name:

Phone #:</td><td>Primary Physician:

Phone #:
Fax #:</td><td>Clinic:</td></tr>
<tr><td>Emergency Contact Name & Phone:</td><td colspan="2">My Representative is:
They can be contacted for:</td></tr>
<tr><td colspan="3">I have a Mental Health Targeted Case Manager: ☐ Yes ☐ No
Name of MHTCM: Phone Number of MHTCM:</td></tr>
</table>

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)***

Initial/Annual:
Update:

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

Initial/Annual:
Update:

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	☐	☐	☐	
Mammogram (Within past 2 years ages 65-75)	☐	☐	☐	

Continence needs (Evaluated by a physician?)	☐	☐	☐	
Colorectal Screening (Up to age 75)	☐	☐	☐	
At Risk for Falls (Afraid of falling, has fallen in the past).	☐	☐	☐	
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)*	☐	☐	☐	
Flu shot *(Annually ages 50+ and persons at high risk.)*	☐	☐	☐	
Tetanus Booster *(Once every 10 years)*	☐	☐	☐	

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

Cholesterol check	☐	☐	☐	
Diabetic routine checks as recommended by physician (Discuss with my care team: Hypertension, Neuropathy, Eye exam, Cholesterol, A1C)	☐	☐	☐	
Other:	☐	☐	☐	
Mental Health Diagnosis (If applicable): ☐ N/A	Managed by a Health Professional? ☐ Yes ☐ No (Psychiatrist, Psychologist, Primary Care Physician) Need Goal? ☐ Yes ☐ No ☐ Declined			
My Medications	I need help with my medications? ☐ Yes ☐ No ☐ N/A (no medications used) If yes, create a goal			
List of Medications *(If not on LTCC)*				
Health Improvement Referral	☐ Yes ☐ Declined ☐ 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)
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					

☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					

Barriers to meeting my goals

Initial/Annual:
Update:
☐ **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: Phone:**
☐ **Other (describe)**

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			
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.

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

Informal, non-paid community supports or resources (i.e., caregiver, neighbor, volunteer):

Informal Provider	Service Provided	Schedule/Frequency

Additional comments, if applicable: