

**AccessAbility Solution ®/ AccessAbility Solution Enhanced®**

**Special Needs Basic Care (SNBC)**

**MEMBER CARE PLAN**

**Information about me**

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| Name: | **Health Plan ID Number:** | **Care Plan Completion Date:** |
| **Phone #:** | **Product:** Choose an item. | **Product Enrollment Date:** |
| **My Address:** | **DOB:** | **Diagnosis:** |
| **Date of My Assessment Visit:**  **Assessment Type:**  **Initial Health Risk Assessment**  **Annual Reassessment**  **Change in My Needs**  **Other** | |
| **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:** | **Primary language is:**  **English Hmong  Spanish**  **Somali  Vietnamese Russian**  **Other (*Type in the “other” language*)**    **Interpreter Needed:  Yes  No**  **Name and number of Interpreter (*If applicable*):** | |

**My Care Team (Interdisciplinary Care Team-ICT)**

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| **Care Coordinator/Case Manager:**  **Name:**  **Phone #:** | **Primary Physician:**  **Phone #:**  **Fax #:** | | **Clinic:** |
| **If applicable: County waiver worker name/contact:** | **If applicable: County waiver program**  **CAC CADI BI (TBI)  DD** | | |
| **Emergency Contact Name & Phone:** | **Power of Attorney/Guardian Name & Phone:** | | |
| **Mental Health Targeted Case Manager:  Yes No**  **Name of MHTCM:** **Phone Number of MHTCM:** | | | |
| **Other Care Team Members Name** | **Relationship** | **Phone Number** | |
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**What’s Important to Me? (e.g. living close to my family, visiting friends)**

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| **Initial/Annual:** |
| **Update:** |

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

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| **Initial/Annual:** |
| **Update:** |

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

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| **Initial/Annual:** |
| **Update:** |

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| **Caregiver listed on HRA: *(Caregivers are unpaid person(s) providing services; if there was no caregiver, the service would have to be purchased.)***  **Yes  No**  **If Yes, how was the caregiver assessment form completed?**  **Declined  Face-to-Face  Telephone  Mail Date Completed:** |

**Care Plan Completion**

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| **SIGNATURE OF CARE COORDINATOR COMPLETING THIS PLAN:** | **DATE:** |
| **CARE PLAN MAILED/GIVEN TO MEMBER** | **DATE:** |
| **CARE PLAN OR SUMMARY MAILED/GIVEN TO PCP**  **(verbal, phone, fax)** | **DATE:** |
| **Communication with Waiver Worker attempted, if applicable** | **DATE:** |

**Managing and Improving My Health**

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| **CONDITION/SCREENING** | **An educational conversation must take place with client on applicable topics. If member needs are identified a goal should be created unless member declines.** | | | |
|  | **Check if educational conversation took place** | **Check if Goal Needed** | **Check if N/A, Contraindicated, Declined** | **Notes** |
| **PREVENTIVE HEALTH** | | | | |
| **Annual Preventive Health Exam** |  |  |  |  |
| **Breast Cancer Screening (women 40+ at PCP recommendation depending on risk factors)** |  |  |  |  |
| **Child and Teen Checkup (up to age 21)** |  |  |  |  |
| **Colorectal Screening**  **(Men and Women 50+ or earlier depending on risk factors)** |  |  |  |  |
| **Dental Exam** |  |  |  |  |
| **Flu shot *(Annually)*** |  |  |  |  |
| **Hearing Exam** |  |  |  |  |
| **Pneumovax (*Immunize those at high risk once, and again after 5ys)*** |  |  |  |  |
| **Tetanus Booster (As needed and once every 10 years)** |  |  |  |  |
| **Vision Exam** |  |  |  |  |
| **OTHER HEALTH EDUCATION** | | | | |
| **Blood Pressure:**  **(Blood Pressure Goal is <140/80 to age 75)** |  |  |  |  |
| **Cholesterol check (all ages as directed by PCP)** |  |  |  |  |
| **Continence needs (Evaluated by a physician)** |  |  |  |  |
| **Diabetic routine checks as recommended by physician (Discuss with care team: Hypertension, Neuropathy, Eye exam, Cholesterol, A1C)** |  |  |  |  |
| **Medication Compliant?** | **Yes  No (If not compliant with medications please create a goal).** | | | |
| **Safe Disposal of Medication Discussion** | I have discussed safe disposal of medications and was provided supporting documents.  Yes  N/A Comments: | | | |
| **Risk for Falls (Afraid of falling, has fallen in the past).** |  |  |  |  |
| **Other Assessed Needs** | **Discuss and provide education about any of the following assessed needs.** | | | |
| **Education/Employment** |  |  |  |  |
| **Family Planning** |  |  |  |  |
| **Housing** |  |  |  |  |
| **Rehabilitative Services** |  |  |  |  |
| **Transportation** |  |  |  |  |
| **Other:** |  |  |  |  |
| **Other:** |  |  |  |  |
| **Other/Notes:** | | | | |
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| **Behavioral Health/Substance Use Diagnosis (If applicable):**  N/A | Managed by a Health Professional?  Yes  No  (Psychiatrist, Psychologist, Primary Care Physician)  Need Goal?  Yes  No  Declined (If goal needed, document in member goals section)  Notes: | | | |
| **Disease Management/Complex Case Management Referral** | Yes No Diagnosis/Notes: | | | |

1. **My Goals (Issues, needs, and all areas of concern identified on the HRA must be addressed in the Care Plan)**

| **My Goals** | **Intervention/Supports Needed** | **Target Date** | **Monitoring Progress/Goal Revision date** | **Date Goal Achieved /Not Achieved (Month/Year)** |
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**Additional updates/notes about my goals:**

**Barriers to meeting my goals**

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| **Initial/Annual:** |
| **Update:** |
| **No barriers identified** |

**My follow up Plan**

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| **Follow-up Plan:**  **Contact Once a Month for 3 Months**  **Contact 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 need help finding alternative housing * I need help coordinating with my waiver case manager * I can no longer do some things that I had been able to do by myself (such as meal preparation, bathing, bill paying) * I need help finding a behavioral health provider or health care 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 |

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| **Emergency Plan:**  **As discussed with patient and/or family, in the event of an emergency member will: (check all that apply)**  **Call 911**  **Call Emergency Contact**  **Call Other Informal Support Person Name:** **Phone:**  **Other (describe)**  **Self Preservation/Evacuation Plan:**  **If member is unable to evacuate independently in an emergency, describe evacuation plan:**  **If other self-preservation concerns or plans, describe:** |
| **Essential Services Backup Plan: (*when providers of essential services are unavailable)***  **Member is receiving essential services  Yes  No**  **If Yes, briefly describe member’s backup plan:** |
| **Community-Wide Emergency Plan:**  **In the event of a community-wide disaster, (e.g., public health emergency, flood, tornado, blizzard), I will (describe plan):** |
| **Additional Case Notes:** |

1. **Medica AccessAbility Solution® /** **Medica AccessAbility Solution Enhanced® SNBC Service Plan**

**Please include ALL services, i.e. skilled home care, custodial home care, home-and-community-based services, medical supplies, etc. This will include services being provided/paid for by other sources (waiver programs, informal supports, etc.)**

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| **Provider Name** | **Service/Support Provided** | | **Payment Type** | | **Schedule/Frequency** | **Start Date/End Date** |
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| **Informal, non-paid community supports or resources (i.e. caregiver, neighbor, volunteer)** | | | | | | | |
| **Informal Provider** | | **Service Provided** | | **Schedule/Frequency** | | | |
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| **Additional comments, if applicable:** | | | | | | | |