Care Planning and Coordination for MLTC Plans and Health Homes

Section I. Identifying Information:

Name: Last	First		MI
Address: Number & Street	City/Town	State	Zip
Phone: ( ) -	Qualifying Health Home Diagnosis: HIV/AIDS___	SMI ___	2 Chronic Conditions ___
Family/Guardian Information:	Qualifying MLTC Eligibility Criteria Requires more than 120 days of community based LTC Services ____		

Name:	Relationship	In Household	Telephone Number/Email Address
1)		y/n	
2)		y/n	
3)		y/n	
4)		y/n	

II. Joint Care Management Needs Assessment:

Note: The State requires a collaborative, team approach to service coordination between the Health Home and the Managed Long Term Care Plan. **The assigned MLTC Plan care coordinator and the Health Home care manager will assure that duplication of care management service does not occur, and that any in-plan services recommended on the care plan are authorized by the MLTC Plan.** It will be the responsibility of the Health Home and the MLTC Plan care managers to determine who is going to be the lead care manager and it will be reflected and documented on this form under **Section II Referral Acceptance Coordination, Assigned Care Managers.**A description of in-plan and out of plan services of the MLTC Plan will be included in **Part 2** of this form. Utilizing the format in Section III of this form, identify and list the needs/goals which will document collaboration between the MLTC Plan and the HH in order to provide comprehensive, unduplicated care management. The MLTC Plan and the HH must clearly define their respective roles in order to develop a comprehensive, integrated, person-centered care plan. Attach additional pages as necessary. **This form should be completed in conjuction with each reassessment to ensure continuity of care and reflect the long term care expertise of the MLTC Plan and the behavioral health expertise of the Health Home.**

III. Referral Acceptance/Coordination:

Client referred from current CM provider (HH or MLTCP)_____

Date of Referral_____ to (HH/MLTCP)_____

Assigned Care Managers:

Agency	Care Manager	Phone	Contacted
***A**			y/n
***B**			y/n

Reviewed need/reason for joint CM with __ Client __ Other (identify)_____

Date of discussion with other CM on joint service plan: Date / /

Attach the joint service plan when finalized. This form and service plan copy must be kept in both programs' care management records, in addition to intake/assessment/reassessment information.

Dates of Coordination/Discussions:	Multidisciplinary Team Names:
Date / /	
Date / /	
Date / /	
Date / /	
Date / /	

***KEY A = Managed Long Term Care Plan**
B = Health Home

II. Joint Care Management Needs Assessment

#1	
Need/Goal:	
*A Explain the role and task(s) of the MLTCP care manager in achieving this goal:	
*B Explain the role and task(s) of the HH care manager in achieving this goal:	
#2	
Need/Goal:	
*A Explain the role and task(s) of the MLTCP care manager in achieving this goal:	
*B Explain the role and task(s) of the HH care manager in achieving this goal:	
#3	
Need/Goal:	
*A Explain the role and task(s) of the MLTCP care manager in achieving this goal:	
*B Explain the role and task(s) of the HH care manager in achieving this goal:	
#4	
Need/Goal:	
*A Explain the role and task(s) of the MLTCP care manager in achieving this goal:	
*B Explain the role and task(s) of the HH care manager in achieving this goal:	
Supervisor Review and Approval:_____	Date / /

***KEY A = Managed Long Term Care Plan**
B = Health Home