

# Integrated Services Care Plan

Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Parent / Guardian \_\_\_\_\_

Address: \_\_\_\_\_

Alternate Phone \_\_\_\_\_

Member Lives with \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Supervisory Agency \_\_\_\_\_

Contact / Phone \_\_\_\_\_

## Principal Coordinating Doctor – PCD

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

## Care Coordinator-

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

# Integrated Services Care Plan

Medicaid \_\_\_\_\_ County \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder \_\_\_\_\_ ID \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder \_\_\_\_\_ ID \_\_\_\_\_

Dental Insurance \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder \_\_\_\_\_ ID \_\_\_\_\_

Vision Insurance \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder \_\_\_\_\_ ID \_\_\_\_\_

## Care Coordinator

Phone \_\_\_\_\_ Fax \_\_\_\_\_

### Qualifying Diagnosis

### Other Diagnosis

1 \_\_\_\_\_ 1 \_\_\_\_\_

2 \_\_\_\_\_ 2 \_\_\_\_\_

3 \_\_\_\_\_ 3 \_\_\_\_\_

4 \_\_\_\_\_ 4 \_\_\_\_\_

5 \_\_\_\_\_ 5 \_\_\_\_\_

For after hours advice please call your doctor. In a medical emergency call 911 or go to the nearest emergency room.



### III. Specialty Care

#### C. Sub-Specialty Physicians

Clinic Name-Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Clinic Name-Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Clinic Name-Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Clinic Name-Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Clinic Name-Physician \_\_\_\_\_

Clinic Name / Physician / Counselor Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Is the member currently receiving these services? YES NO \_\_\_\_\_

Member Name \_\_\_\_\_ ID Number \_\_\_\_\_

Anticipated Number of Visits \_\_\_\_\_ Hospital Affiliation \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

Anticipated Number of Visits \_\_\_\_\_ Hospital Affiliation \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

Anticipated Number of Visits \_\_\_\_\_ Hospital Affiliation \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

Anticipated Number of Visits \_\_\_\_\_ Hospital Affiliation \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

Anticipated Number of Visits \_\_\_\_\_ Hospital Affiliation \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

\_\_\_\_\_

## IV. Medical Support Services

### G. Vision and Hearing

\* Authorization for new hearing aids will require further documentation from the audiologist prior to ordering the aids.

Audiologist \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Hearing Aid Provider \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Optometry Provider \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Anticipated Number of Visits \_\_\_\_\_ Date of last Audiogram-Include Copy \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

Are new aids needed? YES NO Are new aids ordered? YES NO

Are new ear molds needed? YES NO Are new ear molds ordered? YES NO

Date of last new aids \_\_\_\_\_ Type of aids \_\_\_\_\_

Are new glasses needed? YES NO Are new glasses ordered? YES NO

Date of last new glasses \_\_\_\_\_ Date of last exam \_\_\_\_\_

Number of visits \_\_\_\_\_

### H. Specialized Laboratory and Radiology

Lab / Radiology Facility \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Lab / Radiology Facility \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Studies to be done \_\_\_\_\_

Ordering Physician \_\_\_\_\_

Studies to be done \_\_\_\_\_

Ordering Physician \_\_\_\_\_

## V. Hospital Care Inpatient / Outpatient

### I. Scheduled Medical or Surgical Procedures

Clinic / Hospital \_\_\_\_\_

Procedure \_\_\_\_\_

Member Name \_\_\_\_\_ ID Number \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Clinic / Hospital \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

## VI. Education

School Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Contact Person \_\_\_\_\_

Child Care  
Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

## VII. Rehabilitation Services

### J. Physical, Occupational and Speech Therapies

Physical Therapy Provider-School \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Physical Therapy Provider \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Occupational Therapy Provider-School \_\_\_\_\_

Address \_\_\_\_\_

Member Name \_\_\_\_\_ ID Number \_\_\_\_\_

Ordering Physician \_\_\_\_\_

Date Scheduled \_\_\_\_\_

Procedure \_\_\_\_\_

Ordering Physician \_\_\_\_\_

Date Scheduled \_\_\_\_\_

Date of last IEP/IFSP \_\_\_\_\_ Date of next IEP/IFSP \_\_\_\_\_

Classroom Type / Program \_\_\_\_\_

Early On Enrolled? YES NO Referred? YES NO Refused? YES NO

Date of last Child Assessment Form completion: \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

Number of Visits \_\_\_\_\_ Contact \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

Number of Visits \_\_\_\_\_ Contact \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Occupational Therapy Provider \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Speech Therapy Provider-School \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Speech Therapy Provider \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Other Rehab Provider \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Number of Visits \_\_\_\_\_ Contact \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

Number of Visits \_\_\_\_\_ Contact \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

Number of Visits \_\_\_\_\_ Contact \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

Number of Visits \_\_\_\_\_ Contact \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

Number of Visits \_\_\_\_\_ Contact \_\_\_\_\_

**VIII. Pharmacy Needs**

**K. All Medications**

Medication and dose

Ordering Physician

Pharmacy Provider

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 \_\_\_\_\_  
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Member Name \_\_\_\_\_ ID Number \_\_\_\_\_

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**L. Medical Supplies obtained from the Pharmacy**

Supplies	Ordering Physician	Pharmacy Provider
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

**M. Oral Nutritional Supplements obtained from the Pharmacy**

Supplement Name	Ordering Physician	Pharmacy Provider / WIC
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

**IX. Medical Equipment**

**N. Durable Medical Equipment** \* Authorization for all Durable Medical Equipment will require a copy of the Rx and letter of medical need from the specialist before ordering.

Equipment Owned \_\_\_\_\_

Equipment Needs - Ordered \_\_\_\_\_

Equipment Rented \_\_\_\_\_

Incontinence Supplies and Quantity \_\_\_\_\_

DME Provider / Incontinence \_\_\_\_\_

Are supplies currently on order with this provider? YES NO Date ordered \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Copy of Rx

Phone \_\_\_\_\_

Fax \_\_\_\_\_

DME Provider \_\_\_\_\_

Is equipment currently on order with this provider? YES NO Date ordered \_\_\_\_\_

Member Name \_\_\_\_\_ ID Number \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

DME Provider \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

**O. Orthotics and Prosthetics** \*Authorization for new Orthotics or Prosthetics will require a copy of the Rx and possibly a letter of medical need before ordering.

O & P Provider \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

O & P Provider \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

**X. Home Health Care Infusion Supplies**

Home Infusion Provider – NUTRITION \_\_\_\_\_

Prescription-Enteral or Parenteral \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Home Infusion Provider – IV THERAPY \_\_\_\_\_

Prescription \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Member Name \_\_\_\_\_ ID Number \_\_\_\_\_

\_\_\_ Copy of Rx \_\_\_ Letter of Medical Need

Fax \_\_\_\_\_

Is equipment currently on order with this provider? YES NO Date ordered \_\_\_\_\_

\_\_\_ Copy of Rx \_\_\_ Letter of Medical Need

Fax \_\_\_\_\_

Is there anything currently on order with this provider? YES NO Date ordered \_\_\_\_\_

\_\_\_ Copy of Rx \_\_\_ Letter of Medical Need

Fax \_\_\_\_\_

Is there anything currently on order with this provider? YES NO Date ordered \_\_\_\_\_

\_\_\_ Copy of Rx \_\_\_ Letter of Medical Need

Fax \_\_\_\_\_

Ordering Physician \_\_\_\_\_

Supplies / Equip used \_\_\_\_\_

Estimated Length of Treatment \_\_\_\_\_

Ordering Physician \_\_\_\_\_

Supplies / Equip used \_\_\_\_\_

## **XI. Other Services**

Social Services: (List)

### Transition Services

OVR Counselor: \_\_\_\_\_ Phone \_\_\_\_\_

### Chiropractic Services

Clinic Name / Provider \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

### Transportation Services

Provider \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

## **XII. Nursing**

### Skilled Nursing Visits

Agency Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Ordering Physician \_\_\_\_\_

### Hourly Nursing

Agency Name \_\_\_\_\_

Member Name \_\_\_\_\_ ID Number \_\_\_\_\_

Social Worker

Treatment Plan and Goals

:

Plan in place \_\_Y \_\_N \_\_N/A

Treatment Plan and Goals

Contact person

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Indication \_\_\_\_\_

Treatment Plan and Goals \_\_\_\_\_

\_\_\_\_ RN \_\_\_\_ LPN \_\_\_\_ AID

Indication \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Ordering Physician \_\_\_\_\_

### Respite Care

Agency Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Ordering Physician \_\_\_\_\_

### Hospice Care

Agency Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Ordering Physician \_\_\_\_\_

### Community Services/ Referrals

Name

_____	_____	_____
_____	_____	_____
_____	_____	_____

Treatment Plan and Goals \_\_\_\_\_  
\_\_\_\_\_ RN \_\_\_\_\_ LPN \_\_\_\_\_ AID

Indication \_\_\_\_\_

Treatment Plan \_\_\_\_\_  
\_\_\_\_\_ RN \_\_\_\_\_ LPN \_\_\_\_\_ AID

Indication \_\_\_\_\_

Treatment Plan \_\_\_\_\_  
\_\_\_\_\_ RN \_\_\_\_\_ LPN \_\_\_\_\_ AID

Member Name \_\_\_\_\_ ID Number \_\_\_\_\_

**XIII. Signature Page**

I have actively participated in the development of this Integrated Care Plan. All the items and procedures have been explained to me. My questions have been answered. I understand and agree with the services described in this plan. I know that I can request additional services be added to this care plan.

Parent / Legal Guardian \_\_\_\_\_ Date Agreed \_\_\_\_\_

Care Coordinator \_\_\_\_\_ Date Completed \_\_\_\_\_

Principal Coordinating Doctor \_\_\_\_\_ Date Reviewed/Agreed \_\_\_\_\_

Print Name \_\_\_\_\_ Tax ID number \_\_\_\_\_ Physician Organization \_\_\_\_\_  
(If Applicable)

Member Name \_\_\_\_\_ ID Number \_\_\_\_\_