**CASE MANAGEMENT MONTHLY REPORT** ☐**LCP** ☐**MFW**

MEMBER:_____ ID#_____ ☐**HV** ☐**Phone**

Spoke with: ☐Member ☐Caregiver ☐Other: _____

PCA:_____ ☐Present ☐Not Present

☐30 Day Follow-up ☐90 Day Follow-up ☐Routine Monthly Visit ☐ASR in the Home ☐PCA Family Member

Member evaluated for High Risk per agency high risk criteria: Yes☐ No☐ Is Member High Risk? Yes☐ No☐

**(If high risk, HR Monitor Checklist completed monthly for updates in change in member's status.)**

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| **MEMBER'S/FAMILY'S RESPONSE TO CARE GIVEN AND TO CAREGIVER**<br>◯ Case management only, no PCA hours in plan<br>Name of person assisting with ADLs and IADLs:<br>_____<br>◯ Unstaffed (weekly telephone calls to member must be completed) | ❑ Pleased with caregiver<br>❑ Member and caregiver have good rapport<br>❑ Member pleased with all services<br>❑ Request change in caregiver<br>❑ Member and caregiver have an uncomfortable relationship<br>Date of problem reported to office: _____<br>Name of person receiving report: _____ |
| **MONITORING OF OBJECTIVES AND EXPECTED OUTCOMES**<br>**PERSONAL CARE**: Member is clean, odor free and groomed. Reports no falls while bathing.<br>PCA units for personal care:_____ | ❑ Met<br>❑ Staffing not available for all units<br>❑ Member frequently not available for PCA<br>❑ Needs increased / decreased services. |
| **HOMEMAKING:** Member is managing household tasks. Home is as clean as member desires, pathways are clear, has clean clothes, groceries and supplies. PCA is completing all tasks per service plan goals. Review each task from Service Plan.<br>PCA units for homemaking: _____ | ❑ Met<br>❑ Staffing not available for all units<br>❑ Member frequently not available for PCA<br>❑ Needs increased / decreased services |
| **ASR:** Ambulation, AROM, PROM, Hoyer Lift, Foley Cath, Ostomy | ❑ Met<br>❑ Staffing not available for units |
| **Respite:** | ❑ Met<br>❑ Staffing not available for units |
| **NUTRITION:** Member has three meals per day. No weight loss reported.<br>❑ Home delivered meals, delivered per service plan<br>Number per week: _____ | ❑ Met<br>❑ Not met<br>❑ Needs increased / decreased services<br>PCA units for preparation of meals: _____ |
| **CASE MANAGEMENT:** Member has all services coordinated. There is no duplication or harmful gaps in services. Appropriate payer will be responsible for services.<br>❑ Home Health / Hospice in Home<br>Name of Home Health Agency: _____<br>Home Health Services (include frequency):_____ | ❑ Met<br>❑ Not met<br>❑ Home charts in the home<br>❑ Current service plan/goals in home chart<br>Date of contact with office if not in the home : _____<br>Dates of Community Service Plan Certification: _____ |

**Page 1 of 2 - Continued on Next Page.** **Initials of Case Manager: _____**

## CASE MANAGEMENT MONTHLY REPORT – Page 2

**Member ID:** _____

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|---|---|
| **CHRONIC HEALTH:** Member is managing chronic health problems. Member has no disease complications that have not been reported to the physician. Member has all needed medications and supplies. Medications are current and member takes medications as prescribed.<br>☐ Adjustments needed in Living Choice or Waiver services<br>Specify: | ❑ Met<br>❑ Vendor awaiting Rx from physician<br>❑ Vendor awaiting prior authorization<br>❑ Vendor awaiting equipment / supplies<br>❑ Member not pleased with: |
| **SAFETY:** Member is safe at home. No emergencies have been reports without immediate assistance. Member is able to verbalize emergency plans for weather, evacuation, location of telephone numbers for emergency contact and services. | ❑ Met<br>❑ Not Met<br>❑ Case management intervention needed<br>Specify: |
| **OTHER OBJECTIVES:** | |
| **OBSERVATION OF SERVICE DELIVERY**<br>Case management intervention to correct:<br>☐ Adjustment needed in service plan<br>Specify: | ❑ Duties carried out adequately<br>❑ Plan followed as written<br>❑ Changes in plan is communicated and member/legal agent agree with changes in plan<br>❑ PCA is competent to complete to carry out plan<br>❑ PCA does not know duties<br>❑ PCA not following plan<br>❑ PCA needs further training |
| **HEALTH ASSESSMENT OF MEMBER**<br>Date of 6 month RN evaluation: _____ Copy received and reviewed by case manager: Yes☐ No☐<br>Date of scheduled physician visit: _____<br>Name of physician: _____<br>Reason for physician visit: _____<br>Hospitalization: _____ | |
| **PHYSICAL, EMOTIONAL, SOCIAL, FUNCTIONAL ENVORNMENTAL ASSESSMENT OF MEMBER SINCE LAST VISIT IS:**<br>☐ Case management intervention needed<br>Specify: | ❑ Changed<br>❑ Specify<br>❑ Unchanged<br>❑ Services are being delivered as authorized<br>❑ Service plan adequate as written<br>❑ Member pleased with caregiver |
| **Date of last hospital/rehab/nursing home stay?** | |

Member satisfied with all services? Yes☐ No☐ If no, list service not satisfied with: _____

** * OTHER COMMENTS - SEE ATTACHED PROGRESS NOTE*

**Member Signature:** _____

**SIGNATURE/TITLE:** _____

CASE MANAGEMENT MONTHLY REPORT Date: _____ Time in: _____ Time out: _____

January February March April May June July August September October November December