**UPCAP CARE MANAGEMENT**

**RELEASE OF CONFIDENTIAL MEDICAL INFORMATION**

**PHYSICIAN**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B**:\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS#**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MA RECIPIENT ID** #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above-named person has been assessed and deemed eligible for enrollment into UPCAP’s Care Management Program. The medical information being requested is necessary to validate medical eligibility and is also useful in determining service eligibility. We request this information based on your knowledge of the above named individual and to facilitate our development of a service care plan.

**DIAGNOSIS:** Primary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Illness: Yes\_\_\_\_\_ No\_\_\_\_\_

**DATE INDIVIDUAL WAS LAST SEEN**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimated number of months which medical treatment will be required for the diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimated number of office / clinic visits: \_\_\_\_\_\_\_\_\_X PER \_\_\_\_\_Week \_\_\_\_\_Month \_\_\_\_\_Other Specify\_\_\_\_\_\_\_\_

Will this change? YES\_\_\_\_\_\_\_\_ (When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) NO \_\_\_\_\_

**CURRENT MEDICATIONS:** (PER CLIENT REPORT, IF CHANGES OR ADDITIONS, PLEASE LIST)

| NAME AND STRENGTH | FREQ. | PRESCRIBING M.D. | NAME AND STRENGTH | FREQ. | PRESCRIBING M.D. |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| SEE ATTACHED MEDICATION LIST |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**ALLERGIES**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TREATMENT PRESCRIBED**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AMBULATORY STATUS**: (1) Independently (2) With Assist (3) Non-Ambulatory

**PROGNOSIS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RECENT SURGERY DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If applicable, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIET:** 

**MD APPROVES USE OF HOME DELIVERED MEALS:** YES\_\_\_\_\_ NO\_\_\_\_\_\_

**CONTINUED ON REVERSE SIDE**

**DOES INDIVIDUAL REQUIRE SPECIAL TRANSPORTATION?** YES\_\_\_\_\_ NO \_\_\_\_\_

**DOES INDIVIDUAL NEED TO BE ACCOMPANIED TO MEDICAL APPOINTMENTS?** YES\_\_\_\_\_ NO \_\_\_\_\_

**UPCAP’S SUPPORTS COORDINATORS ASSESSED THE NEEDS IN THE BELOW CATEGORIES:**

| **PERSONAL CARE ACTIVITIES:**\_\_\_Eating \_\_\_Dressing\_\_\_Meal Preparation \_\_\_Toileting\_\_\_Transferring \_\_\_ Shopping/Errands \_\_\_Bathing \_\_\_Mobility \_\_\_Laundry \_\_\_Grooming\_\_\_Taking Meds \_\_\_Housework | **SERVICES NEEDED:**\_\_\_Specialized Feeding \_\_\_Suctioning\_\_\_Catheters or leg Bags\_\_\_Bedsore Prevention\_\_\_Colostomy Care\_\_\_Range of Motion\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| --- | --- |

**DO YOU AGREE AND CERTIFY NEED FOR ASSISTANCE? \_\_\_\_\_ YES \_\_\_\_\_ NO**

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NOTE: Client is no longer in the work force.

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By my signature, I attest that the above named individual meets the nursing facility level of care as established by the Michigan Department of Health and Human Services, and that the person desires to participate in UPCAP’s Care Management/Waiver Program.

**Physician Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CLIENT AUTHORIZATION OR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am voluntarily participating in UPCAP Care Management. I have been informed of this request for medical information and hereby authorize release of all medical records and relevant information which may be requested as a result of my participation in this program. This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client’s (Authorized Representative) Signature** **Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness or Care Manager Signature** **Date**

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**PLEASE RETURN THIS FORM (OR A COPY) TO:**

**UPCAP - CARE MANAGEMENT**

**[Insert Local Office Address]**

**Thank you for your assistance. If you have any questions, please call us at**

**[Insert Phone Number]**