Date:

Minnesota Care Management Center
ICBS Monthly Update Form

MEDICA®

Client Name: _____ DOB:_____Client Medica ID#_____

Agency: _____

Case Manager Name/ telephone #:_____

Risk Assessment (Any "yes" requires a goal to be listed below)

Suicidal Ideation? Y ☐ N ☐ Homicidal Ideation? Y ☐ N ☐ ER Past Month Y ☐ N ☐

Hospitalization Past Month Y ☐ N ☐ Substance Abuse Issues? Y ☐ N ☐

Medication Adherence Issues Y ☐ N ☐ Appointment Adherence Issues Y ☐ N ☐

Diagnoses: _____

Medical conditions: _____

Current Symptoms: _____

_____

List specific goals completed this month or specific steps taken toward goals:_____

_____

_____

_____

_____

What Interventions do you plan to implement with the member in the upcoming month? (MH, SA, Medical, Social Services, etc….please be specific): _____

_____

_____

_____

_____

Is the member eligible for Rule 79 Case Management (TCM)? Y ☐ N ☐

If so, has referral been made? _____

Do you need any assistance in arranging health plan services? Y ☐ N ☐

If so, please describe:_____

Case closed? Y ☐ N ☐ Date closed: _____