PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Individualized Care Plan

Date: _____

Patient Information			
First Name:	Last Name:		DOB:
Sex:	Pronouns:	Primary Language:	

Address Information			
Street:			
City:	State:	Zipcode:	County:
Mailing Address Same as Home Address:		☐ Yes	☐ No
Street:			PO Box:
City:	State:	Zipcode:	County:

Contact Information
Email:
Phone #:
Phone #:

Other Contacts		
Family/Caregiver	Name:	May we contact if needed?
Email:		Phone #:
Community Team	Name:	May we contact if needed?
Email:		Phone #:
Program Representative	Name:	May we contact if needed?
Email:		Phone #:

Insurance Information		
Medi-Cal ID:		
Primary Insurance	Plan:	Group #:
Policy #:		Member ID:
Secondary Insurance	Plan:	Group #:
Policy #:		Member ID:

Acuity			Self-Management Assessment		
☐ High Risk	☐ Low Risk	☐ No Risk	☐ Poor	☐ Moderate	☐ Good

Social Determinants of Health	
If current member has any changes to SDoHs, check the box and fill out only the changes: ☐	
Education:	Employment Status:
Income Status:	Food Security:
Housing Stability:	Transportation:
Support Networks:	

ECM Criteria (Select all that apply)				
Populations of Focus		***For current member, if no longer meets criteria, fill applicable criteria***	***If current member and new criteria identified, fill applicable criteria***	***If new member, fill applicable criteria***
Adult	*Unhoused*	☐	☐	☐
	Individuals At Risk for Avoidable Hospital or ED Utilization	☐	☐	☐
	At Risk of Institutionalization & Eligible for LTC Services	☐	☐	☐
	Nursing Home Transition to the Community	☐	☐	☐
	Serious Mental Health/Substance Use Disorder	☐	☐	☐
	Pregnant and Postpartum at Risk for Adverse Perinatal Outcomes	☐	☐	☐
	Transitioning from Incarceration w/ Complex Health Needs to Community	☐	☐	☐
Child	*Unhoused*	☐	☐	☐
	Individuals At Risk for Avoidable Hospital or ED Utilization	☐	☐	☐
	Serious Mental Health/Substance Use Disorder	☐	☐	☐
	Pregnant and Postpartum at Risk for Adverse Perinatal Outcomes	☐	☐	☐
	Birth Equity	☐	☐	☐
	Transitioning from Incarceration	☐	☐	☐
	Complex Medical / Behavioral / Development Needs	☐	☐	☐
	Involved in Child Welfare	☐	☐	☐
	Enrolled in California Children's Services (CCS) or Whole Child Model (WCM) w/ Additional Needs Beyond CCS Condition	☐	☐	☐

Physical Health

Active Medical Problems (chronic conditions, fall risk, speech, etc.)	Past Medical History

Not Req'd. for members less than 18		Members with diabetes or who are on antipsychotic medication	
Blood Pressure:	Date:	A1C Levels:	Date: _____ _____A1C%
	____Systolic / ____Diastolic		

Dental/Oral Health

Active Dental Problems/Concerns

Dental Provider's Name:	Last Visit Date:
Dental's Office:	Next Visit Date:

Mental Health History

	If PHQ-2 Score is normal, do not proceed to PHQ-9 Test. If PHQ-2 Score is not normal proceed to PHQ-9 Test	
	Date:	
	PHQ-2 Score	PHQ-9 Score

If prescribed Antidepressants or Psychotherapy, please provide more information below
(E.g.: adherence to medication regimen; improvements in mental health after therapy)

Substance Use Disorder Screening

Alcohol Use	Drug Use
Frequency:	Frequency: Drug Type
AUDIT-C Score	DAST-10 Score

If other information requires further disclosure, please provide below:

Hospitalizations

Admissions in the last 6 mos:	Emergency Dept. visits in the last 6 mos:

Durable Medical Equipment

___Hospital Bed	___Oxygen	Other
___Wheelchair	___Walker	

Physician Visits

Primary Care Physician visits in the last 6 mos:	Last Visit Date:
Physician's Name:	Physician's Office:
Specialist visits in the last 6 mos:	Last Visit Date:
Specialist's Name:	Specialist's Office:

Medication List	Indication

Allergies

Long-Term Support Services

Community Based Adult Services (CBAS)	Service Name
Multi-purpose Senior Services Program (MSSP)	Service Name
Home Health Agency	Service Name
Palliative Care	Service Name
Hospice Care	Service Name
In-Home Support Services (IHSS)	Hours/month

Advanced Care Planning

Surrogate Decision Maker	☐ Has One	☐ Needs One	☐ Does Not Want One
Living Will	☐ Has One	☐ Needs One	☐ Does Not Want One
Advance Directive	☐ Has One	☐ Needs One	☐ Does Not Want One
POLST	☐ Has One	☐ Needs One	☐ Does Not Want One
Power of Attorney	☐ Has One	☐ Needs One	☐ Does Not Want One
Code Status	☐ DNR	☐ Full Code	☐ Limited Interventions

Goals	
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met

Referrals Needed

ECM Staff Member Name: Date

ECM Staff Member Signature: Date