CASE MANAGEMENT
COMPLEX CASE MANAGEMENT
FILE SUMMARY

Attachment A

_____ _____ DOB/Age: _____
Member Last Name First Name

Member ID# _____ PCP: _____ CM: _____

CM Referral Source: _____ Date Rec'd: _____

Reason for CM Referral/DX: _____
_____

Date Case **Opened** to CCM: _____ Member/Caregiver Contact Info:
_____

Date Case **Closed** to CCM: _____ _____

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Checklist:

- ☐ Member/caregiver introduced to CM services: _____ accepted _____declined
- ☐ Initial assessment of health status performed: _____ (date)
  - ☐ Clinical history & medications
  - ☐ ADL assessment completed
  - ☐ MH/cognitive status/psychosocial
  - ☐ Life planning (advance directive)
  - ☐ C&L preferences/limitations
  - ☐ Hearing/speech, vision needs, preferences or limitations
  - ☐ Caregiver resources and involvement (willingness/capability)
  - ☐ Evaluation of available benefits and community resources
- ☐ Individual CM plan with prioritized goals (self-management plan as applicable)
- ☐ Evidence-based clinical guidelines (e.g., Milliman CM criteria)
- ☐ Barriers/reassessments/progress

Follow Up:

- ☐ CCM Program Member Satisfaction Survey sent: _____ (date)