Oregon Health Authority

Babies First!, Family Connects, Nurse Family Partnership and CaCoon Targeted Case Management (TCM)

TCM Service Plan and Goals

Annual TCM Review due: ________________ or more often as indicated by change in individual need

Goals for client/caregiver-identified priorities:

1. ____
2. ____

Agreed upon goals (case manager and client/caregiver) (check all that apply):

☐ Demonstrate ability to identify and independently access health services (e.g., medical home, PNC, WCC, Imm, vision, dental) by:

Completion Target Date: ______________ Date Completed: _____________

☐ Demonstrate ability to identify and independently access education services or quality child care (e.g., EI, Special Education, Head Start, high school) by:

Completion Target Date: ______________ Date Completed: _____________

☐ Demonstrate ability to identify and independently access social services (e.g., transportation, support system, housing, food, SSI) by:

Completion Target Date: _____________ Date Completed: _____________

☐ Other (specify):

Completion Target Date: ______________ Date Completed: ______________

Planned activities/interventions to achieve goals (check all that apply):

☐ Ongoing identification of strengths
☐ Ongoing identification of barriers
☐ Assist client/caregiver in increasing knowledge of community resources
☐ Assist client/caregiver in working with needed services and agencies
☐ Assist client/caregiver in completing paperwork for: ____________________
☐ Assist client/caregiver to gain skills to become an effective advocate
☐ Assist client/caregiver to expand support system
☐ Problem-solve with client/caregiver to obtain needed services
☐ Support client's/caregiver's efforts to adhere to the schedules for treatment and services
☐ Other: _______________________

Client Name: ______ DOB: ______ Date of Service: ______

Planned referral/linking (check all that apply):

- ☐ Childcare
- ☐ Clothing and basic supplies
- ☐ Dental care
- ☐ Education services, child
- ☐ Education services, adult
- ☐ Food security
- ☐ Health insurance/OHP
- ☐ Housing stability
- ☐ Income stability
- ☐ IPV resources
- ☐ Legal aid
- ☐ Medical specialty care or therapies
- ☐ Mental health care
- ☐ PN/PP care
- ☐ Respite care
- ☐ Substance use (ATOD)
- ☐ Supplemental Security Income
- ☐ Transportation
- ☐ Well-care visit/immunizations
- ☐ WIC
- ☐ Other: ______________

Planned monitoring (check all that apply):

- ☐ Monitor the client's/caregiver's ability to access and utilize needed resources
- ☐ Monitor for commitment to TCM Service Plan
- ☐ Monitor progress toward goals
- ☐ Other (specify): ____________________________
- ☐ Other (specify): ____________________________
- ☐ Other (specify): ____________________________

Notes:

RN Case Manager Signature: ____________________ Today's Date: ______________

Medicaid number: _________________ Diagnosis: ____________________________

Client Name: [ ] DOB: [ ] Date of Service: [ ]