

Monthly Case Manager Contact

Date: _____

Veteran's Name: _____

ADNA CM: _____

Contact Information:

Dates of contacts during month: _____

Types of contact during month:

Home Visit Phone Telehealth Other

Updates for Past Month:

Medical

None New Medical Issue Hospitalization Inpatient/Respite

If yes, explain:

Falls

Number of falls last month? _____ Did Veteran receive medical treatment? Yes No

If yes, where? _____ Date: _____

Personal Care Needs

Personal care hours fulfilled/utilized? Yes No

If no, why?

Changes in Activities of Daily Living (ADLs) in past month:

Eating Dressing Behavior Bathing Bed Mobility
Walking Grooming Toileting Transfers None

If yes, explain:

Equipment needs:

Other changes/needs:

Budget Review: Review Monthly Service Report with Veteran/Surrogate

Is Veteran on budget? Yes No

If no, explain:

Plan:

FMS Review:

Tempus issues/concerns (timesheets, payroll, etc.):

Yes

No

If yes, explain:

Plan:

Resource Needs:

None

Food Insecurity

Transportation

Utility Help

Housing instability

If yes, explain:

Plan:

Summary:

ADNA Case Manager Signature

Date