VIP ONECARE SERVICES CAN HELP YOU:

- Develop a plan to guide you, your doctors and other providers
- Make sure you get the right services at the right time
- Learn about your conditions and how you can help yourself be as healthy as possible
- Get the services and support you need when you are discharged from a hospital or other health care facility
- Reach your health goals with the help of your family and/or other helpers or caregivers
- Make sure you get the supports you need to stay in your home

Valeo
Behavioral Health Care

valeotopeka.org

For more information, please contact your KanCare health plan or visit:

www.kancare.ks.gov

aetna™

855-221-5656
711 (TTY)

sunflower health plan

877-644-4623
711 (TTY)

UnitedHealthcare

877-542-9238
711 (TTY)

Valeo
Behavioral Health Care

VALEO INTEGRATION PARTNERSHIP (VIP)

ONECARE PROGRAM

CELEBRATING OVER 50 YEARS OF RECOVERY SERVICES

2401 SW 6th St.
Topeka, KS 66606
785-233-1730

24-Hour Crisis Line: 785-234-3300

valeotopeka.org

WHAT IS VIP ONECARE?

The VIP OneCare Program provides extra support to you if you have a serious health condition and are part of KanCare. The program can help you manage your needs to improve your health and well-being. The goal of the program is to help you be as healthy as possible within the community.

VIP ONECARE SERVICES

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Member and Family Support
- Referral to Community Supports and Services

HOW CAN THE PROGRAM HELP YOU?

The VIP OneCare Program can:

- Provide support to help you manage your overall health
- Make sure you get the right services at the right time to be as healthy as possible
- Help you get needed support services in your community

HOW MUCH DOES IT COST?

Nothing – VIP OneCare services are free to individuals who are eligible.

ARE YOU ELIGIBLE?

You may be eligible if you have:

- KanCare
- Asthma, Schizophrenia or Severe Bipolar Disorder
- Chosen Valeo Behavioral Health Care as your OneCare provider

HOW DOES THE PROGRAM WORK?

OneCare services are a benefit under your KanCare health plan. OneCare services are only available to those that qualify and have enrolled in the program. Individuals in the VIP OneCare Program will work with a VIP Comprehensive Care Coordinator. The Care Coordinator will stay in touch with you and the other agencies you work with to make sure everyone knows what you need to stay as healthy as possible.

WILL YOU HAVE TO CHANGE THE PEOPLE YOU ARE WORKING WITH?

No – You can continue to work with the same people

You can still work with your:

- KanCare Health Plan
- Doctor and/or Nurse
- Mental Health Provider/Counselor
- Other Support People

Other people may actually be added to your team to help you reach your health goals.

HOW DO YOU GET IN THE PROGRAM?

If you are eligible, you should receive an invitation letter from your KanCare health plan.

You will need to complete that letter and send it back to your KanCare health plan.

If you have not received an invitation letter or have lost it, ask your provider for a referral to OneCare.

VIP ONECARE PROGRAM
2401 SW 6th St.
Topeka, KS 66606

(785) 233-1730
valeotopeka.org
24-Hour Crisis Line: (785) 234-3300

OneCare Member Assignment

Name: Click here to enter text.

CTOne ID Number: Click here to enter text. **Medicaid ID Number:** Click here to enter text.

MCO: ☐ Aetna ☐ Sunflower ☐ United

☐ Member does not have an open Valeo chart. VIP CCC will need to contact Amie Sirridge to administratively open the chart.

Address: Click here to enter text. **Telephone Number:** Click here to enter text.

OneCare Start Date: Click here to enter text. **HAP Due Date:** Click here to enter text.

Diagnoses: Click here to enter text.

Service Codes to be Used:

☐ **Non SUD Codes**	☐ **SUD Codes**
800 – Comprehensive Care Management	806 – SUD Comprehensive Care Management
815 – Comprehensive Care Management HAP	816 – SUD Comprehensive Care Management HAP
801 – Care Coordination	807 – SUD Care Coordination
802 – Health Promotion	808 – SUD Health Promotion
803 – Comprehensive Transitional Care	809 – SUD Comprehensive Transitional Care
804 – Member & Family Support	810 – SUD Member & Family Support
805 – Referral for Community Supports & Services	811 – SUD Referral for Community Supports & Services

Tasks:

Date Completed	**Task**
	Notify Valeo providers of member being in the VIP program
	Mail Welcome letter & business card
	Review TP in CTOne
	Identify all treaters & other support persons involved with the member
	Obtain all necessary consents
	Contact member's Primary Care Provider (Notify them of the member being in the VIP program, introduce self & obtain physical & behavioral health diagnostic information)
	Connect member with a PCP, if not already connected
	Complete the Adult Health Assessment
	Complete the HAP within 90 days of start of OneCare
	Provide Lucia a paper copy of the completed HAP with three required physical signatures for scanning into CTOne
	Provide the HAP to other treaters involved in the member's care (e.g., PCP, IDD provider, etc.)
	Refer to Nicole for DPOA assistance, if applicable
	Refer to Nicole for assistance with a Living Will, if applicable

[Date]

Dear [Individual's name]

Welcome to the Valeo Integration Partnership (VIP) OneCare Program. The VIP OneCare Program can provide you extra support to improve your health and well-being. The goal of the program is to help you be as healthy as possible within the community. Services provided will be at no cost to you.

I will be your VIP Comprehensive Care Coordinator. I can help you reach your health goals. I can help you:

- Find a primary care doctor
- Schedule needed appointments
- Get transportation to your appointments
- Link your doctors together
- Make sure you get the services and supports you need to stay in your home
- Coordinate your health care
- Work on your desired health goals

You will not have to change your current health care providers or supports. I will be added to your team.

I look forward to working with you.

Sincerely,

[Name of VIP Comprehensive Care Coordinator]

VIP Comprehensive Care Coordinator

Valeo Integration Partnership (VIP) Program

Member Care/Support Team

Member Name:______________________________________ **DOB:**____________

Name of Person	Type of Provider/Support Person (For example – mom, case manager, primary care provider, etc.)	Contact Information	Date Identified

OneCare Kansas
a program of KanCare, Kansas Medicaid

OneCare Kansas
a program of KanCare, Kansas Medicaid

Valeo Integration Partnership (VIP) Program

Adult Health Assessment (Version 3)

Name:_____ Date of Birth:_____ Date:_____

About You:

Do you have a primary care provider for your healthcare needs? ☐Yes ☐No

If yes, name of provider:_____

Do you work with an individual for your behavioral health needs? ☐Yes ☐No

If yes, name of individual:_____

Do you have vision problems? ☐Yes ☐No

If yes, do you use glasses, contact lens, magnifying glass, etc.? ☐Yes ☐No

Do you have hearing loss and/or use hearing aids? ☐Yes ☐No

Spirituality:

What keeps you going in difficult times? _____

_____

Are you part of a religious or spiritual community? ☐Yes ☐No

If yes, how does that help you?_____

_____

What spiritual beliefs do you find most helpful? _____

_____

Do you need anything to help you cope spiritually at this time? _____

_____

Lifestyle:

How many fruits and vegetables do you eat in a day? (1 fruit or vegetable = 2 cups leafy greens, 1 cup raw or cooked vegetables, 1 cup fresh fruit, 1 cup 100% juice or ½ cup dried fruit)

☐0 ☐1-2 ☐3-4 ☐5-6 ☐7-8 ☐9 or more

How many sugary drinks do you have in a day? (Examples of sugary drinks – regular soda or pop, sports or energy drinks and fruit drinks with added sugar)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 or more

How many unhealthy foods do you think you eat in a day? (Examples of unhealthy foods – chips, fried or fast foods, cookies, doughnuts and candy)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 or more

How often do you do the following exercises?

- Cardio exercise like jogging, cardio machines, aerobic dancing, brisk walking or swimming.
  _____ Days per week _____ Minutes per session
- Strength-building exercise like weightlifting, push-ups, sit-ups, yoga or Pilates.
  _____ Days per week _____ Minutes per session

How many alcoholic drinks do you have in a week? (I drink = 12 oz. bottle of beer or hard cider, 5 oz. glass of wine or 1.5 oz. shot or distilled spirits) _____ Drinks per week

Do you use recreational or street drugs? ☐Currently ☐Previously ☐Never

If you currently use recreational or street drugs, what, how much and how often do you use? _____

When was the last time you used? _____

Do you smoke cigarettes? ☐Currently ☐Previously ☐Never

If you currently smoke cigarettes,

How many do you smoke a day? ____ How many years have you smoked? ____

Do you use any other forms of tobacco like electronic nicotine devices, cigars, pipes, snuff or chewing tobacco? ☐Currently ☐Previously ☐Never

Are you exposed to secondhand tobacco smoke more than once a week for 30 minutes or longer? ☐Yes ☐No

Sleep:

Generally,

What time do you go to bed? _____ What time do you get up? _____

Do you sleep during the day? ☐Yes ☐No

Do you feel rested when you wake up? ☐Yes ☐No

Do you use sleep aides? ☐Yes ☐No

Medical:

In the past year, (excluding pregnancy) how many times have you been:

To the doctor or clinic? ____ Hospitalized overnight? ____ To the emergency room? ____

Do you take medication for any chronic conditions? ☐Yes ☐No

If yes, please list medication and dosage: ☐See attached

_____

_____

Do you have any allergies to medication or anything else? ☐Yes ☐No

If yes, please list all allergies:_____

_____

_____

Do you use any medical equipment like a cane, walker, crutches, nebulizer, diabetic supplies, oxygen, C-PAP, etc.? ☐Yes ☐No

If yes, please list:_____

_____

_____

Do you need help with Activities of Daily Living like bathing, medication, feeding, etc.? ☐Yes ☐No

If yes, please list:_____

_____

_____

Conditions:

Has a doctor ever diagnosed you with:

- Allergies ☐Yes ☐No
- Ankle/leg swelling ☐Yes ☐No
- Arthritis ☐Yes ☐No
- Asthma ☐Yes ☐No
  - Do you have an Asthma Action Plan ☐Yes ☐No
- Cancer - If yes, type: _____ ☐Yes ☐No
- Chronic obstructive pulmonary disease (COPD) or Emphysema ☐Yes ☐No
- Chronic pain ☐Yes ☐No
- Colon polyps ☐Yes ☐No
- Diabetes (Type 1) ☐Yes ☐No
- Diabetes (Type 2) ☐Yes ☐No
- Depression ☐Yes ☐No
- Dialysis – If yes, how many times a week:_____ ☐Yes ☐No
- Heart problems ☐Yes ☐No
- High blood pressure ☐Yes ☐No
- High cholesterol ☐Yes ☐No
- Menopause (women only) ☐Yes ☐No
- Migraine headaches ☐Yes ☐No

- Osteoporosis ☐Yes ☐No
- Stroke ☐Yes ☐No
- Sleep disorder ☐Yes ☐No
- Thyroid disease ☐Yes ☐No
- Urinary problems (For example, leaking urine) ☐Yes ☐No
- Other condition(s) _____ ☐Yes ☐No

Do you have concerns about any condition(s) you have? ☐Yes ☐No

If yes, please identify the condition(s) and concern(s) you have:_____

_____

_____

_____

_____

_____

Lab Tests:

Do you know your:

Blood pressure? ☐Yes ☐No
Total cholesterol? ☐Yes ☐No
LDL ("Bad") cholesterol? ☐Yes ☐No
HDL ("Good") cholesterol? ☐Yes ☐No
Triglyceride level? ☐Yes ☐No
Blood sugar level? ☐Yes ☐No
Hemoglobin A1c level? ☐Yes ☐No

Preventative Screenings and Exams:

Screening	Last completed					
	Less than 1 yr.	1-2 yrs.	2-3 yrs.	3-5 yrs.	5 or more yrs.	Never
Cervical cancer screening (Pap smear) ☐Not applicable Dr. _____						
Prostate exam ☐Not applicable Dr. _____						
Colonoscopy ☐Not applicable Dr. _____						
Physical exam or wellness visit Dr. _____						
Eye doctor appointment Dr. _____						
Dental appointment Dr. _____						

Have you had a flu shot in the last 12 months? ☐Yes ☐No
Have you had the pneumonia vaccine? ☐Yes ☐No
Have you had the shingles vaccine? ☐Yes ☐No
When was your last tetanus shot?_____ (If unknown it is recommended to get one)

How ready are you to make the following health changes?

Health Change	Plan to make change				
	No need to work on	Currently working on	Plan to within next month	Plan to within next 6 months	No plan to work on
Get more cardiovascular exercise					
Get more strength-building exercise					
Eat better					
Manage your weight better					
Get current with your preventative screenings and exams					
Manage your stress better					
Improve your sleep habits					

Patient Health Questionnaire (PHQ-9)

Name:_____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentration on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Add columns: ____ + ____ + ____

TOTAL: ____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Patient Health Questionnaire (PHQ-9)

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (e.g., every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 1

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. Question 2 should be answered only by males and Question 3 only be females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

Segment:
Visit number:

1. In the PAST 12 MONTHS, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

2. In the PAST 12 MONTHS, how often have you had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by males).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

3. In the PAST 12 MONTHS, how often have you had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by females).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

4. In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

5. In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you? Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 2

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 2 is a brief assessment for tobacco, alcohol, and illicit substance use and prescription medication misuse in the PAST 3 MONTHS ONLY. Each of the following questions and subquestions has two possible answer choices- either yes or no. Check the box to select your answer.

1. In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you usually smoke more than 10 cigarettes each day? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, did you usually smoke within 30 minutes after waking? ☐ Yes ☐ No

2. In the PAST 3 MONTHS, did you have a drink containing alcohol? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you have 4 or more drinks containing alcohol in a day?* (Note: This question should only be answered by females). ☐ Yes ☐ No

b. In the PAST 3 MONTHS, did you have 5 or more drinks containing alcohol in a day?* (Note: This question should only be answered by males). ☐ Yes ☐ No

*One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

c. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop drinking? ☐ Yes ☐ No

d. In the PAST 3 MONTHS, has anyone expressed concern about your drinking? ☐ Yes ☐ No

3. In the PAST 3 MONTHS, did you use marijuana (hash, weed)? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use marijuana at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of marijuana? ☐ Yes ☐ No

4. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

5. In the PAST 3 MONTHS, did you use heroin? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using heroin? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of heroin? ☐ Yes ☐ No

6. In the PAST 3 MONTHS, did you use a prescription opiate pain reliever (for example, Percocet, Vicodin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using an opiate pain reliever? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever? ☐ Yes ☐ No

7. In the PAST 3 MONTHS, did you use a medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of medication for anxiety or sleep? ☐ Yes ☐ No

8. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of a medication for ADHD (for example, Adderall or Ritalin)? ☐ Yes ☐ No

9. In the PAST 3 MONTHS, did you use any other illegal or recreational drug (for example, ecstasy/molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ('spice'), whip-its, etc.)? ☐ Yes ☐ No

If "Yes", answer the following questions:

In the PAST 3 MONTHS, what were the other drug(s) you used?

Comments:

Medical Durable Power of Attorney and Living Will Worksheet

This is the information *required* to complete the MDPOA and Living Will Documents. Please take a moment to review this information and make sure that the Member knows who they would like to designate as their Agent and any Alternates. They may have up to two Alternates. It is crucial to provide as much contact information as possible.

Name of Member aka Principal - First, Middle, Last

_____

Address - City, State and Zip Code

_____

Agent - First, Middle, Last **Date of Release on File** _____

_____

Address - City, State and Zip Code

_____

Home Phone _____ Cell Phone _____

Work Phone _____ Email Address _____

First Alternate Agent - First, Middle, Last **Date of Release on File** _____

_____

Address - City, State and Zip Code

_____

Home Phone _____ Cell Phone _____

Work Phone _____ Email Address _____

Second Alternate Agent - First, Middle, Last **Date of Release on File** _____

_____

Address - City, State and Zip Code

_____

Home Phone _____ Cell Phone _____

Work Phone _____ Email Address _____

Limitations -

_____

Other Wishes -

_____

_____

Example: Adhere to Native American Rites and rituals as written and in a separate document and provided to the Agent.

Primary Care Physician - Name **Date of Release on File** _____

_____

Address - City, State and Zip Code

_____

Phone _____ Fax _____

Medical Provider - Name **Date of Release on File** _____

_____

Address - City, State and Zip Code

_____

Phone _____ Fax _____

Medical Provider - Name **Date of Release on File** _____

_____

Address - City, State and Zip Code

_____

Phone _____ Fax _____

_____ **Hospital Preference**: The University of Kansas Health System St. Francis Campus, 1700 SW 7th St, Topeka, KS 66606

OR

_____ **Hospital Preference**: Stormont Vail Hospital and Trauma Center 1500 SW 10th Ave, Topeka, Ks 66604

OR

Name and Address - City, State and Zip Code of Alternate Facility

_____

_____

Location of Documents -

_____

_____

_____

Examples – "in our safe", bedside table, My Chart, etc.

OneCare Kansas HAP - Medication/Reconciliation

First Name:	MI:	Last Name:	Medicaid ID:	Date:

Medication Name	Dosage and Frequency	Prescribed By	Additional Information about Medications