



# Healthcare Case Management Checklist Template

## Intake & Assessment

Initial client information gathering and needs assessment.

**Client Full Name**

Write something...

**Date of Intake**

Enter date...

**Presenting Problem/Reason for Referral**

Write something...

**Age**

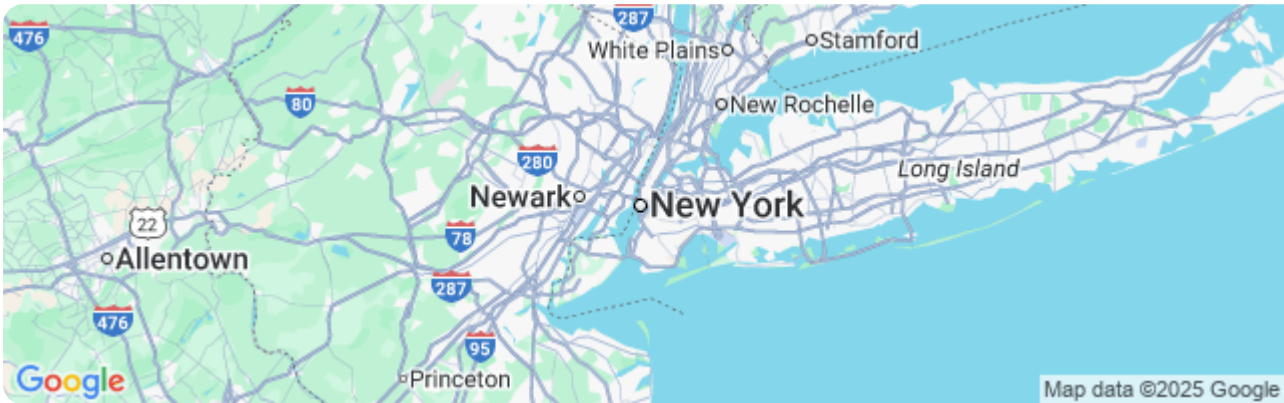
Enter a number...

### Primary Language

- ☐ English
- ☐ Spanish
- ☐ Other

### Client Address

 [Set My Current Location](#)



### Referral Documents (if applicable)

 [Upload File](#)

### Emergency Contact Information

Write something...

## Care Plan Development

Creation of a personalized care plan with measurable goals.

### Client Strengths & Resources

Write something...

### Client Goals (Short-Term)

Write something...

### Client Goals (Long-Term)

Write something...

### Goal Completion Timeline (Weeks)

Enter a number...

### Primary Focus Area

- ☐ Medical
- ☐ Social
- ☐ Financial
- ☐ Behavioral Health

### Services Required

- ☐ Medical Appointments
- ☐ Medication Management
- ☐ Therapy
- ☐ Financial Assistance
- ☐ Housing Support
- ☐ Transportation

### Care Plan Review Date

Enter date...

## Service Coordination

Scheduling and coordinating necessary services (medical, social, financial, etc.).

### Referral Source

- ☐ Hospital
- ☐ Physician
- ☐ Social Services
- ☐ Family
- ☐ Self-Referral
- ☐ Other

## Services Scheduled

- ☐ Medical Appointments
- ☐ Therapy Sessions
- ☐ Transportation
- ☐ Financial Assistance
- ☐ Legal Aid
- ☐ Housing Support
- ☐ Other

## Appointment Date

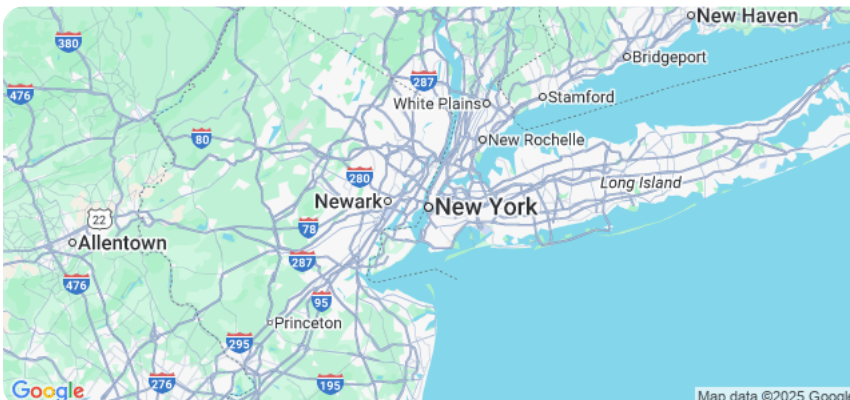
Enter date...

## Appointment Time

Enter time...

## Service Location

 [Set My Current Location](#)



## Provider Name

Write something...

### Coordination Notes

Write something...

## Progress Monitoring & Evaluation

Regularly tracking client progress towards goals and adjusting care plan as needed.

### Progress Monitoring Date

Enter date...

### Goal Progress (Scale of 1-10)

Enter a number...

### Observed Progress & Challenges

Write something...

### Overall Assessment (Improving, Stable, Declining)

☐ Improving

☐ Stable

☐ Declining

### Areas Requiring Adjustment

- ☐ Medical
- ☐ Social
- ☐ Financial
- ☐ Emotional
- ☐ Housing

### Plan Modifications & Next Steps

Write something...

## Communication & Collaboration

Maintaining consistent communication with client, family, and other relevant parties.

### Last Communication Date with Client

Enter date...

### Communication Method

- ☐ Phone
- ☐ Email
- ☐ In-Person
- ☐ Video Conference

### Summary of Communication & Key Discussion Points

Write something...

### Stakeholders Involved in Communication

- ☐ Client
- ☐ Family Member
- ☐ Physician
- ☐ Social Worker
- ☐ Insurance Provider

### Next Scheduled Communication Date

Enter date...

## Documentation & Record Keeping

Ensuring accurate and complete documentation of all case management activities.

### Date of Record Creation

Enter date...

### Summary of Initial Assessment

Write something...

### Progress Notes - Date Specific


Write something...



### Care Plan Updates

- ☐ No Change
- ☐ Minor Adjustment
- ☐ Major Revision

### Supporting Documentation (e.g., Medical Records, Reports)

 Upload File

### Communication Log (Dates, Parties, Summary)

Write something...

### Case Manager Signature

## Crisis Intervention & Support

Responding to and managing client crises and providing appropriate support.

### Crisis Level (Severity)

- ☐ Low
- ☐ Moderate
- ☐ High
- ☐ Imminent Danger

### Description of Crisis Event

Write something...

### Date of Crisis Event

Enter date...

### Time of Crisis Event

Enter time...

### Immediate Actions Taken

- ☐ Contacted Emergency Services (911)
- ☐ Provided Emotional Support
- ☐ Ensured Safety of Client & Others
- ☐ Contacted Family/Designated Support
- ☐ Other


### Details of Actions & Client Response

Write something...

### Client's Distress Level (1-10)

Enter a number...

## Supporting Documentation (e.g., notes, photos)

 Upload File

# Discharge Planning & Transition

Planning for client discharge and ensuring a smooth transition to continued care.

## Planned Discharge Date

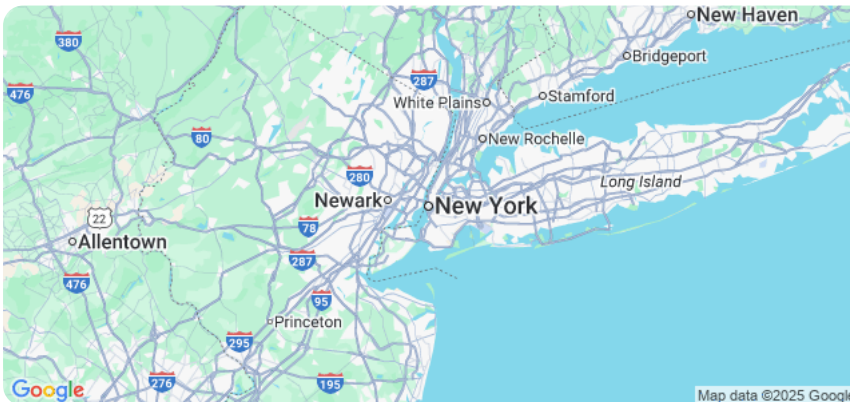
Enter date...

## Reasons for Discharge

Write something...

## Post-Discharge Residence

 Set My Current Location



### Discharge Destination (e.g., Home, Assisted Living, Rehab)

- ☐ Home
- ☐ Assisted Living
- ☐ Rehabilitation Facility
- ☐ Hospital
- ☐ Other

### Services Required Post-Discharge

- ☐ Home Health
- ☐ Medical Transportation
- ☐ Meal Delivery
- ☐ Social Worker Follow-Up
- ☐ Financial Assistance
- ☐ None

### Contact Information for Post-Discharge Support (Family/Friends/Community Resources)

Write something...

### Discharge Instructions Document

 Upload File

## Regulatory Compliance

Adherence to relevant healthcare regulations and ethical guidelines.

### HIPAA Compliance Status

- ☐ Compliant
- ☐ Partially Compliant
- ☐ Non-Compliant
- ☐ N/A

### Last HIPAA Training Completion Date

Enter date...

### State Reporting Requirements

- ☐ Required
- ☐ Not Required
- ☐ N/A

### Summary of Regulatory Updates Reviewed

Write something...

### Mandated Reporting Obligations

- ☐ Yes
- ☐ No
- ☐ N/A

### Supporting Documentation (e.g., policy updates)

 Upload File

# Financial Management

Assisting with financial resources and navigating insurance processes.

## Client's Annual Income

Enter a number...

## Primary Funding Source

- ☐ Medicare
- ☐ Medicaid
- ☐ Private Insurance
- ☐ Self-Pay
- ☐ Other

## Insurance Coverage Details (Policy Number, Effective Dates)

Write something...

## Insurance Policy Renewal Date

Enter date...

## Financial Assistance Programs Applied For

- ☐ SNAP
- ☐ TANF
- ☐ Section 8
- ☐ None

**Outstanding Medical Bills**

Enter a number...

**Notes on Financial Resources & Challenges**

Write something...