Plan Type ☐ New ☐ Reassessment

SERVICE PLAN

Member Name				DOB		Medicaid #	
	Last	*First*	*Middle*				
Address					County		
	Street	*City*	*State*	*Zip*			

Service Code	Types of Service	Provider	# of Units	Freq	Units/ Year	Rate/ Unit	PAY SOURCES: Informal	Private Pay	Other	Medicare	State Plan	Admin. CM	ADvantage Title XIX
						TOTAL							
												Total ADvantage Title XIX	

CASE MANAGEMENT

DATE SUBMITTED	
Authorization Date for Initial Services (See ADv 4 Date)	
Date Notice of Change of ADvantage Program Services given & explained to member	
CM Signature	
CM Name (Print or Type)	
CM Agency (Print or Type)	CM Supervisor Review (Signature)

MEMBER SIGNATURE

I have been informed of my right to request a fair hearing if I disagree with any action taken regarding my Medicaid services. A fair hearing is intended to safeguard my rights and interests by affording me due process. I understand I have the right to appeal any action of the Oklahoma Department of Human Services which I consider improper by reporting my complaint verbally or in writing to a local county office

Agreed to Service Plan ☐Yes ☐No Date

Member Signature

Witness Signature	Witness Signature

Justification

ADvantage PC Start Date: _____

Institutional Discharge Date: _____