



County

CONSUMER CHANGE OF PROVIDER

Consumer Name			
	<i>Last</i>	<i>First</i>	<i>Middle</i>
Address			
	<i>Street</i>	<i>City</i>	<i>State</i> <i>Zip</i>
Medicaid #			

A. CONSUMER CHOICE AND CONSENT

I have chosen _____ as my Provider.

I authorize the Oklahoma Department of Human Services to share with the above named Provider my medical or social information necessary to arrange and evaluate services that will enable me to regain or maintain my personal independence.

I understand my information will not be released in any way that would identify me to other agencies or agents without my prior written consent.

This authorization is in effect for one (1) year from the original date of my signature. I understand that I may revoke this authorization at any time.

Signature of Consumer or Legal Agent <i>(If Consumer signs with mark, two witnesses are required)</i>		Date	
Signature of Witness	Date	Signature of Witness	Date

B.

_____ agrees to provide the services listed within three (3) days of receipt of a copy of the Member's Certified Service Plan (ADv6g); or within the time designated on the certified emergency service plan.

Service	Proposed # of Units	Per Day/Week/Month/Year

Authorized Name/Authorized Representative	
<i>Please print</i>	
Signature of Authorized Agency Representative	Date

C. CASE MANAGER AGREEMENT

Signature	Agency	Date