



**ADvantage Program
SERVICE PLAN COST SHEET**

| | | | | | |
|------------------|------------|----------------|-----------------|---------------------------------------|-----|
| Member last name | First name | Middle initial | Medicaid number | Plan type [] New [] Reassessment | |
| Street address | | City | County | State OK | Zip |

Codes: Frequency (Freq): **D**=Daily **W**=Weekly **M**=Monthly **Y**=Yearly

Pay Source: **A**=ADvantage **I**=Informal **M**=Medicare **P**=Private Pay **S**=State Plan **O**=Other

| Code | Type of Service | Provider | # Units | Freq | Units per year | Rate per Unit | Pay source | Amount |
|------|-----------------|----------|---------|------|----------------|---------------|------------|--------|
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|-----------------------------------|------|
| Initials of member or legal agent | Date |
|-----------------------------------|------|

| | | | | |
|------------------|------------|----------------|-----------------|---------------------------------------|
| Member Last Name | First Name | Middle Initial | Medicaid Number | Plan Type [] New [] Reassessment |
|------------------|------------|----------------|-----------------|---------------------------------------|

TOTAL AMOUNT BY PAY SOURCE.

| | | | | | |
|----------------|-------------------|-------------|----------------|------------------|----------------------------------|
| Informal \$ | Private Pay \$ | Other \$ | Medicare \$ | State Plan \$ | ADvantage Title XIX \$ |
|----------------|-------------------|-------------|----------------|------------------|----------------------------------|

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.

Agree to service plan **Yes** **No**

I have been informed of available services to meet my assessed need for assistance and of the qualified providers of each of these services in my area, from which I have freely selected my services and providers of those services.

Agree to services **Yes** **No**

| | | | | |
|--|------------|----------------------------|------------|-----------------|
| Signature of member or legal agent _____ Date _____ | | | | Justifications: |
| If member signs with a mark, two witnesses are required. | | | | |
| Signature of witness _____ | Date _____ | Signature of witness _____ | Date _____ | |

CASE MANAGEMENT.

| | |
|--|--|
| Date submitted: _____ | Case management agency _____ |
| Authorization date for initial services: _____ | |
| Date Form 02CB016E, Notice of Change in ADvantage Services, given to member: _____ | Case manager name (please print or type) _____ |

| | | | |
|---|------------|--|------------|
| Signature of case manager _____ | Date _____ | Signature of case manager supervisor _____ | Date _____ |
| ADvantage personal care start date: _____ | | Institutional discharge date: _____ | |