



ADvantage Program
SERVICE PLAN COST SHEET ADDENDUM

Member last name, First name, Middle initial, Medicaid number, Plan begin date, Plan end date, Street address, City, County, State OK, Zip

Total cost of ADvantage services prior to this addendum: \$ \_\_\_\_\_

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

List each service to be ended on the existing service plan cost sheet

Table with 11 columns: Begin date, End date, Service code, Type of service, Provider, # Units, Freq, Total units, Unit rate, Pay source, Amount

List each service to be added to the existing service plan

Table with 11 columns: Begin date, End date, Service code, Type of service, Provider, # Units, Freq, Total units, Unit rate, Pay source, Amount

Total cost of ADvantage services after this addendum: \$ \_\_\_\_\_

Initials of member or legal agent, Date

Member last name	First name	Middle initial	Medicaid number	Plan begin date: Plan end date:
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**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 that I consider improper by reporting my complaint verbally or in writing to a local human service center.

**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 services and providers of services.

**Agree to services**  Yes  No

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

**CASE MANAGEMENT.**

Case manager (please print or type)	Case management agency	Date Submitted:
Signature of case manager	Date	Date Form 02CB016E, Notice of Change in <i>ADvantage</i> Program Services, given to member:
Signature of case management supervisor	Date	