LONG TERM CARE ADMINISTRATION

☐ **Living Choice**   ☐ **Medically Fragile**

COMMUNITY SERVICE PLAN ADDENDUM

Participant Name				**SoonerCare ID**	
	Last	*First*	*M.I.*		

REVISED SERVICES AND GOALS															
Put Appropriate Amount for the Pay/Support Source: I=Informal; P=Private Pay; O=Other; M=Medicare; SP=State Plan; SC=Self Care															

SERVICE/SUPPORT

Service line to be ended:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/Year	Rate/Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

Service line to be added:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/Year	Rate/Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

GOALS

Expected Outcome	Action Steps	Monitoring of Expected Outcome
		How will outcome be monitored?
		HOW OFTEN will monitoring occur?
		HOW LONG will monitoring continue? ☐ Plan Year ☐ Until Expected Outcome is met

Participant/Legal Representative Initials_____   Page _____ of _____
      NOTE: Full signature required on final page only. Initials required for all other pages.

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OKHCA Revised 10-27-2015

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<table>
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Participant Agrees to Addendum: ☐ Yes ☐ No	**Date Submitted:**	
	TC/CM Name (Print or Type):	
Signature of Participant or Legal Agent **Date** *(If Participant signs with a mark, two witnesses are required.)*	**TC/CM Signature:**	
Witness Signature and Date:	**TC/CM Supervisor Signature:**	
Witness Signature and Date:	**TC/CM Agency:**	
Supporting Documentation:	**Program – Administrative Use Only**	

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