LONG TERM CARE ADMINSTRATION

Living Choice	☐Medically Fragile

COMMUNITY SERVICE PLAN

Participant Name			SoonerCare ID	
	Last	First	M.I.	

A. HOUSING INFORMATION		
Housing Supplements (Check all that apply):		
 □ Low-Income Housing Tax Credits □ HOME Dollars □ CDBG Funds □ Housing Choice Vouchers □ Housing Trust Funds 	Section 811 202 Funds USDA Rural Housing Funds Veteran's Affairs Housing Funds Funds for Home Modifications	 ☐ Funds for Assistive Technology related to Housing ☐ Other ☐ Not Applicable
Living Arrangements: Will Participant live with family? Yes No	Housing Type: Home – owned by Participant Home – owned by family member	 ☐ Apartment – not assisted living ☐ Apartment – assisted living ☐ Group home of no more than 4 people

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B. LONG TERM GOAL	
CHALLENGES - OPTIONAL	
STRENGTHS - OPTIONAL	

C. SE	RVICES	S AND GOA	LS - #1												
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VICE	Service Code	Type of Service		Service rovider	# of Units	Freq.	Units/ Year	Rate/ Unit	Informal	Private Pay	Other	Medicare	State Plan	Self Care	Program
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SERV	ICES A	ND GOALS	- #3												
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SERV	ICES A	ND GOALS	- #6												
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SERV	ICES A	ND GOALS	- #7												
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SERV	ICES A	ND GOALS	- #22												
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SERVICES AND GOALS - #25															
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S	ERV	ICES A	ND GOALS	- #26														
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CES A	ND GOALS	- #27												
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F. VERIFICATION By initialing the following statements, I affirm	n that:								
I am in agreement with this Comm	unity Transition Plan.	A list of waiver services and provider agencies was provided and discussed with me.							
		Submission Date:	Personal Care Services Begin Date:						
Signature of Participant or Legal Agent (If Participant signs with a mark, two with	Date esses are required.)	Institutional Discharge Date:							
Signature of Witness	Date	TC/CM Name (Printed/Typed)							
Signature of Witness	Date	Signature of TC/CM	Date						
		Signature of TC/CM Supervisor	Date						
Supporting Documentation		TC/CM Agency	Date						
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