

LONG TERM CARE ADMINISTRATION

Living Choice

Medically Fragile

IDT MEETING

Participant Name				SoonerCare ID	
	<i>Last</i>	<i>First</i>	<i>M.I.</i>		

Start	Stop	Time	Units

Signature	Title	Relationship/Agency

Agenda Goals:

1. Educated Participant to the philosophy, purpose and service the program provides. Yes No
2. TC/CM determined if other payment sources were available to purchase needed services prior to using Medicaid funding. Yes No

IDT Progress Notes:

The Participant has received the following information:

- Participant Assurances, Rights and Responsibilities
- Reporting Suspected Abuse, Neglect and Exploitation
- SoonerRide Brochure
- OKHCA Complaint/Grievance Form
- Request for a Fair Hearing Form
- Other _____ (i.e. agency brochure and agency orientation)

I, _____, have been given the above information. I have had the information explained to me and have been given the opportunity to ask questions so that I fully understand the information.

Member's Signature

Date

TC/CM Signature

Date

TC/CM Name (please print)

TC/CM Agency

Total Units: _____