LONG TERM CARE ADMINISTRATION
ALTERNATIVE FUNDS REQUEST FORM

Fax form to Long Term Care ADMINISTRATION: (405) 530-7265

Participant Name				**SoonerCare ID**	
	Last	*First*	*MI*		

TC/CM: ***Please complete and attach supporting case notes.***

Agency: TC/CM:

Date of Service From: Date of Service To:

Total # of Units Requested: Code: ☐ Standard ☐ Very Rural Rate: $ 0.00

List Documents Obtained for Member (i.e. Birth Certificate, Photo ID, SSN) :

Cost to Obtain Documentation(s):

Total amount requested (total units requested + cost for docs obtained):

TC/CM Supervisor:

1. Has TC/CM submitted member's discharge/withdrawal form? ☐ Yes ☐ No
2. Has TC/CM attached progress note documentation supporting units requested? ☐ Yes ☐ No

Supervisor Name: Supervisor Signature: Date:

To be completed by Long Term Care ADMINISTRATION Staff

Date Received: Date Reviewed: LCP Coordinator:

Documentation Review

☐ Progress notes reviewed

☐ Alternative Funds Request Form reviewed

☐ Additional information needed

Comments:

Total # of Units approved:
Total amount approved:
Invoice #