LONG TERM CARE ADMINISTRATION

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

PROVIDER COMMUNICATION

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

A. EVENT CHANGE

_____ Hospital Admission DATE

_____ Vacation Begin DATE

_____ Temp Nursing Facility Placement DATE

_____ Other Begin DATE (Please Specify) _____

_____ Suspension BEGIN DATE

_____ Hospital Discharge DATE

_____ Vacation End DATE

_____ Discharge DATE

_____ Other End DATE

_____ Suspension END DATE

B. ADDRESS CHANGE

Current Address				
	Street	***City***	***State***	***Zip***
New Address				
	Street	***City***	***State***	***Zip***

_____New Address effective DATE

_____Updated Phone Number (if necessary)

Comments

Type of qualified residence (Select one of the following):

- ☐ Home owned by participant
- ☐ Home owned by family member
- ☐ Apartment leased by participant, not assisted living
- ☐ Apartment leased by participant, assisted living
- ☐ Group home of no more than 4 people

Participant lives with family members:

- ☐ Yes
- ☐ No

C. TC/CM CHANGE

Current TC/CM			
New TC/CM		**Effective Date**	
Submitted by	**Agency**		**Date**