UAI / PLAN OF CARE

Customer Name: _____ Social Security #: _____ Medicaid #: _____

Provider Name: _____ Provider ID #: _____

Case Management Initiated: _____ Medicaid Eligibility Approved: _____
(Date) (Date - if after date initiated)

MEDICAID CLIENTS ONLY:

Initial Authorization: _____ Reauthorization: _____
(Must submit to DMAS prior to billing) (Must request 2 weeks prior to end date)

GOALS: *(Circle one or more)*

1. To assist client to remain in his/her own home with supports, as necessary.
2. To assist client in attaining and maintaining appropriate independent functioning based on his/her capabilities.
3. To assist in arranging out-of-home placements as appropriate with either client/guardian consent or court orders.
4. Short-term assistance to access services.

Other Goals: _____

UNMET NEED FROM UAI SUMMARY	MEASURABLE OBJECTIVE TO MEET IDENTIFIED NEED	TASK(S) TO BE DONE TO MEET OBJECTIVE	EXPECTED TIME FRAME	DATE RESOLVED

Client Name: _____ Social Security # _____ Medicaid # _____

UNMET NEED	MEASURABLE	TASK(S)	EXPECTED	

FROM UAI SUMMARY	OBJECTIVE TO MEET IDENTIFIED NEED	TO BE DONE TO MEET OBJECTIVE	TIME FRAME	DATE RESOLVED

SIGNATURES _____ _____ _____ _____

(Recipient of Services) (Date) (Case Worker) (Date)

CASE MANAGER COMMENTS:

Enrolled by DMAS: Service Effective _____ Thru End Date _____ DMAS Analyst _____ Date Entered