

UAI / PLAN OF CARE

Customer Name: _____ Social Security #: _____ Medicaid #: _____
 Provider Name: _____ Provider ID #: _____
 Case Management Initiated: _____ (Date) Medicaid Eligibility Approved: _____ (Date - if after date initiated)

MEDICAID CLIENTS ONLY:

Initial Authorization: _____ (Must submit to DMAS prior to billing)
 Reauthorization: _____ (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	
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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 _____