LONG TERM CARE ADMINISTRATION

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

IDT MEETING

Participant Name				**SoonerCare ID**	
	Last	*First*	*Middle*		

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
3. Does a family member currently or wish to provide PCA/ASR or PDN services to the member? ☐ Yes ☐ No
   If yes, please list the family members name and relationship to the member in the IDT progress notes below.

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: _____