# 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** |