

# UAI / PLAN OF CARE

Customer Name: \_\_\_\_\_

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: \_\_\_\_\_

Medicaid # \_\_\_\_\_

Unmet Need from UAI Summary	Measurable Objective to meet Identified Need	Task(s) to be done to meet Objective	Expected 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 \_\_\_\_\_