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OREGON DEPARTMENT OF Human Services
Aging and People with Disabilities

Branch:	Prime number:	Case name:
Worker name:		
Worker phone:	Ext.:	Date:

Service Plan Short Form

Consumer 1

Last name: _____ First name: _____ Prime: _____
Full address (*including city/state/ZIP*): _____
Phone: _____ Program: ☐ Title XIX ☐ OPI ☐ OPI-Pilot ☐ OPIM ☐ SPPC ☐ MAGI

Homecare workers (HCWs) and in-home care agency actions 2

Current HCW actions:

HCW name: _____ Provider number: _____
Pay period start date: _____ Pay period end date: _____
Voucher number: _____ Edit voucher: ☐ Yes ☐ No Void voucher: ☐ Yes ☐ No
Authorization: Hours: _____ Miles: _____

Relief HCW actions:

Relief HCW name: _____ Provider number: _____
Pay period start date: _____ Pay period end date: _____
Voucher number: _____ Edit voucher: ☐ Yes ☐ No Create new voucher: ☐ Yes ☐ No
Authorization: Hours: _____ Miles: _____

Relief agency name: _____ Provider number: _____
Pay period start date: _____ Pay period end date: _____
Voucher number: _____ Edit voucher: ☐ Yes ☐ No Create new voucher: ☐ Yes ☐ No
Authorization: Hours: _____ Miles: _____

Other/comments* 3

Authorization 4

_____ _____
Worker's signature Date

* If the case doesn't fall into the above sections, please explain here.