eXPRS Plan of Care - Service Delivery Report Form

Customer Name:	Prime:	Month:	Year:
Provider Name:		Provider Number:	
CDDP/Brokerage: **Resource Connections of Oregon**		SC/PA Name:	
Service Authorized:	Units:	Type:	Frequency:

Service Delivered On: Time Period: ☐ 1st-15th or ☐ 16th-end of month

Date	Start/Time IN	End/Time OUT	Total Hours	# of Clients
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CDDP/Brokerage: **Resource Connections of Oregon**	SC/PA Name:		

SERVICE GOAL:

PROGRESS NOTES (attach additional pages, as needed):

RECIPIENT/EMPLOYER VERIFICATION:

I affirm that the data reported on this form is for actual dates/time worked by the provider delivering the service/supports listed to the recipient, that it does not exceed the total amount of service authorized for the recipient and was delivered according to the recipient's service plan and provider/recipient service agreement.

____

Customer Employer or Employer Rep Signature Date

PROVIDER/EMPLOYEE VERIFICATION:

I affirm that the data reported on this form is for actual dates/time I worked by the delivering the service/supports listed to the recipient, that it does not exceed the total amount of service authorized and was delivered according to the recipient's service plan and provider/recipient service agreement. I further acknowledge that reporting dates/time I worked in excess of the amount of service authorized for me or not consistent with the recipient's service plan may be considered Medicaid Fraud.

____

Provider/Employee Signature Date

☐ I authorize CDDP/Brokerage staff to enter the data reported on this from into eXPRS on my behalf for claims creation and payment. __________ (provider initials).

CDDP/BROKERAGE REVIEW:

This service delivery report has been reviewed and is consistent with the recipient's service plan and authorized service limits.

____

CDDP/Brokerage Rep Signature Date

Providers submit this completed/signed form to the
CDDP or Brokerage that authorized the service delivered.