

1/2019

eXPRS Plan of Care - Services Delivered Form

4/16- 4/30/91



Oregon Department of Human Services
Express Payment & Reporting System (eXPRS)

eXPRS
 Express Payment & Reporting System

eXPRS Plan of Care - Services Delivered Form

Customer Name: [REDACTED]

Prime: [REDACTED]

Provider Name: [REDACTED]

Provider Num: [REDACTED]

CM Organization: Multnomah Case Management Provider

SC/PA Name: [REDACTED]

Service: SE49/OR526 - Attendant Care, home or comm/NA - Not Applicable

Service Delivered On:

Date	Start/Time IN	End/Time OUT	Total Hours for Entry	Group? (yes/no)
4/16/2019	08:00 AM	04:00 PM	8:00	No
4/17/2019	08:00 AM	04:00 PM	8:00	No
4/18/2019	08:00 AM	04:00 PM	8:00	No
4/19/2019	08:00 AM	04:00 PM	8:00	No
4/22/2019	08:00 AM	04:00 PM	8:00	No
4/23/2019	08:00 AM	04:00 PM	8:00	No
4/24/2019	08:00 AM	04:00 PM	8:00	No
4/25/2019	08:00 AM	04:00 PM	8:00	No
4/26/2019	08:00 AM	04:00 PM	8:00	No
4/29/2019	08:00 AM	04:00 PM	8:00	No
4/30/2019	08:00 AM	04:00 PM	8:00	No
			88:00	TOTAL HOURS

Customer Name:
Provider Name:
CM Organization:

[REDACTED]

[REDACTED]

[REDACTED]

eXPRS Plan of Care - Services Delivered Form

Multnomah Case Management Provider

Prime: PA600U7V
Provider Num: 824911
SC/PA Name: Carlos Rangel

SERVICE GOAL:

Health care Residential Transportation Recreation Socialization

PROGRESS NOTES (attach additional pages, if needed):

Ultrasound at OHSU waterfront - Anthony diagnosed w/ non-alcoholic fatty liver disease. Recommend wt loss, exercise, change in diet. More exercise since meeting w/ his provider. Visit friends in Astoria
Irritable, focused on spending money at end of month not sleeping

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 and was delivered according to the recipient's service plan and provider/recipient service agreement.

Anthony Langerin
Customer Employer or Employer Rep Signature

Date: 5-1-19

PROVIDER/EMPLOYEE VERIFICATION:

I affirm that the data reported on this form is for actual dates/time I worked 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 worked in excess of the amount of service authorized or not consistent with the recipient's service plan may be considered Medicaid Fraud.

Theresa Langerin
Provider/Employee Signature

Date: 5-1-19

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

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

5/1/2019

eXPRS Plan of Care - Mileage Driven Form



Oregon Department of Human Services
Express Payment & Reporting System (eXPRS)

eXPRS Plan of Care - Mileage Driven Form

Customer Name: [REDACTED]

Prime: [REDACTED]

Provider Name: [REDACTED]

Provider Num: [REDACTED]

CM Organization: Multnomah Case Management Provider

SC/PA Name: [REDACTED]

Service: SE49/OR004 - Comm Transp, Mileage/WE - Community

Service Delivered On:

Date	Total Miles for Date	Group? (yes/no)	Purpose of Trip / Service Goal ** this information is required - write in, as needed
4/16/2019	47.0	No	OHSU waterfront + Lunch
4/18/2019	25.0	No	OHSU Richmond
4/19/2019	20.0	No	Milwaukee
4/26/2019	227.0	No	Astoria round trip visit
	319.0		TOTAL MILES

5/1/2019

eXPRS Plan of Care - Mileage Driven Form

Customer Name: [REDACTED]

Prime: [REDACTED]

Provider Name: [REDACTED]

Provider Num: [REDACTED]

CM Organization:

SC/PA Name: [REDACTED]

Multnomah Case Management Provider

SERVICE GOAL:

TRANSPORTATION, RECREATION, HEALTH CARE, SOCIALIZATION

PROGRESS NOTES (attach additional pages, if needed):

MD visits and trip to Astoria

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 and was delivered according to the recipient's service plan and provider/recipient service agreement.

Anthony Langvin
Customer Employer or Employer Rep Signature

Date: 5-1-19

PROVIDER/EMPLOYEE VERIFICATION:

I affirm that the data reported on this form is for actual dates/time I worked 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 worked in excess of the amount of service authorized or not consistent with the recipient's service plan may be considered Medicaid Fraud.

Theresa Langvin
Provider/Employee Signature

Date: 5-1-19

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(provider initials)

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