DEPARTMENT OF HEALTH AND HOSPITALS
Aging and Adult Services

Agreement to Provide Services

Recipient Name: _____ **Date:**

Recipient Medicaid #: _____ **Provider #:** _____
(Your Agency's Provider Number)

Recipient SSN: _____ **Provider Name:** _____
(Your Company's Name)

A representative from our agency met with _____
(Recipient's Name)
on _____. We have reviewed his/her Plan of Care that has been approved by
(Date of Meeting with Recipient)
the Department of Health and Hospitals.

We agree to provide services to this recipient according to the:

- ☐ Initial Plan of Care dated .
- ☐ Reassessment Plan of Care dated .
- ☐ Status Change Plan of Care dated .

We understand that Xerox State Healthcare, LLC will not be able to issue an authorization to our agency until they receive this form signed by both the recipient or their personal representative and our agency representative.

_____ _____
Recipient Signature **Date of Signature**

_____ _____
Personal Representative Signature **Date of Signature**

_____ _____
Provider Agency Representative Signature **Date of Signature**

Long Term Care - Access Services
2900 Westfork Drive, Suite 540; Baton Rouge, LA 70827
Phone #: 877.456.1146 (TDD 855.296.0226) • Fax #: 866.246.8511

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