AGED AND DISABLED WAIVER
REQUEST FOR DISCONTINUATION OF SERVICE

Attach this form and supporting documentation to the Member's Record in CareConnection©.

Date:_____

Member Information:

Last Name:_____ First Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____ County:_____

Phone Number:_____ Date of Birth:_____

Medicaid Number:_____

Legal Representative Information (if applicable):_____Phone Number:_____

Address:_____

REASON FOR REQUEST:

☐ No Services have been provided for 180 continuous days. Date of last service: _____(required)

☐ Unsafe environment: must attach supporting documentation with request for closure.

☐ Member noncompliance with program: must attach supporting documentation with request for closure.

☐ Member no longer desires services: must attach Member's written request with signature.

Requesting Agency:_____

Mailing Address:_____

Phone:_____ Fax:_____

Other ADW Provider (HM or CM Agency):_____

Phone:_____ Fax:_____

_____
Printed Name of Person Making Request:

_____ _____ _____
Signature of Person Making Request Title Date

NOTE: If the request is approved by the Bureau of Senior Services, a notification of discontinuation of services will be mailed to the member. A copy of the notice will also be sent to the Case Management Agency and the Personal Assistance/Homemaker Agency or for Personal Options - PPL.