# AGED AND DISABLED WAIVER
# CASE MANAGEMENT NOTIFICATION OF CASE CLOSURE

Date_____

TO:_____
Economic Services Worker

FAX Number_____

**********

Last Name: _____ First Name: _____ MI: _____

Address: _____ DOB: _____

Medicaid Number:_____

**********

Case Management Agency: _____

Address: _____ Phone: _____ Fax: _____

Closure Date: _____

Hearing Requested: Yes _____ No_____ Date of Hearing Request: _____

Last Date of Service: _____

Reason for
Closure:_____
_____
_____
_____

Case Manager Signature: _____ Date: _____ Time: _____

Comments:
_____
_____
_____
_____

Completed form is to be FAXED to the ESW when the case closure has been approved by BoSS.
**Note: Upload to ADW CareConnection©*