PERSONAL CARE
REQUEST FOR DISCONTINUATION OF SERVICE

Attach this form and supporting documentation to the Member's Record in PC CareConnection© and fax to the OA at 304-558-6647.

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: _____

Address: _____

REASON FOR REQUEST:

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

☐ Persistent non-compliance with program: must attach supporting documentation with request for closure.

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

☐ Member no longer medically eligible for PC services.

Requesting Agency: _____

Mailing Address: _____

Phone: _____ Fax: _____

Other Provider (PA or CM Agency if dual services case): _____

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.