AGED AND DISABLED WAIVER
REQUEST FOR ADULT DAY CARE SERVICES

Date: _____

Participant Information:

Last Name: _____ First Name: _____

Street Address: _____

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

Phone Number: _____ Date of Birth: ____/_____/_____

Medicaid Number: _____ Anchor Date_____

Units Requested:

1 Day = 1 Unit for either half day or full day.

_____ Total Number of Half Day Units: T2021 U8 (Minimum of 4 Hours)

_____ Total Number of Full Day Units: T2021 U4 (Minimum of 7 Hours)

Maximum Units for 1 Service Year is 261.

Requesting CM Agency: _____

Phone: _____ Fax: _____ Email: _____

Adult Day Care Service Agency: _____

Note: The service once approved should be documented in the participants ADW Service Plan or Service Plan Addendum.

If a participant chooses to transfer service agencies, a new request must be submitted to Acentra.

Please submit the completed form to Acentra Health via Fax or Email.

Email: WVADWaiver@kepro.com

Fax: 866-212-5053