AGED AND DISABLED WAIVER
REQUEST FOR DISCONTINUATION OF SERVICE

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

Date: _____

Participant 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:

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

___ Unsafe environment: must attach support documentation with request for closure.

___ Participant non-compliance with program: must attach supporting documentation with request for closure.

___ Participant no longer desires services: must attach Participant's written request with signature.

___ Participant no longer requires services.

___ ADW Services are no longer sufficient to safely maintain ADW participant in a home setting.

Requesting Agency: _____

Mailing Address: _____

Phone: _____ Fax: _____

Other ADW Provider (PA or CM Agency): _____

Phone: _____ Fax: _____

_____ **Email Address of Person Making Request:_____**
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 Participant. A copy of the notice will be sent to the Case Management Agency and the Personal Attendant Agency or for Personal Options – PPL.