

AGED AND DISABLED WAIVER FORMS INSTRUCTIONS

Form Name: Aged and Disabled Waiver Request for Service Level Change (Policy Section 501.18.2 K)

Purpose: To assess an ADW participant's need for an increase in their Service Level if the participant is a service level A, B, or C and only when there is a substantial change in the participant's medical condition. Note: Participants who are appealing a denial of medical eligibility will remain at their current Service Level pending a Fair Hearing decision. The UMC will not review a request for an increased Service Level for such participants.

1. Document ADW Participant information:

- Participant's First and Last Name
- Birth Date
- Medicaid Number
- Address to include street, city, state and zip code
- County
- Legal Representative, if applicable
- Phone Number
- Participant/Legal Representative must sign request
- Enter current PAS date

2. Document Agency Information:

- Agency Name
- Address to include street, city, state and zip code
- Phone Number
- Fax Number
- Participant/Legal Representative Signature

3. The required following documents must be submitted with the **Request for Service Level Change**:

- A completed copy of the **Request for Service Level Change** with original signatures, *i.e.*, ***"signature of member on file" is not acceptable.***
- A narrative explaining the need for Service Level Change.
- A statement from a physician, nurse practitioner or physician's assistant explaining the need for Service Level Change. Statement must be on the medical professional's letterhead. Applicable Lab results, hospital discharge summary dated no later than one month prior to, or one month following, the request for an increased Service Level.
- Current ADW PAS
- Current Service Plan that includes Personal Attendant Log (PAL)
- Proposed PAL Update

4. Information that **will not** be considered includes:

- Verbal or telephonic statements.
- Letters from family, neighbors, friends, or Case Management and Personal Attendant staff **without** an attached MD's, DO's, ANP's or PA's documentation or hospital discharge summary.

5. A completed Request for Service Level Change with all required documentation **must** be submitted to KEPRO for review in order to determine whether additional hours are warranted. This request may or

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may not result in a change in the Service Level. ***Send all required documents to: KEPRO, 100 Capitol Street, Suite 600, Charleston, WV 25301. Fax: 866-212-5053.***

6. Notice of the determination will be sent to the Participant (or legal representative) and the Personal Attendant Agency, or if a Personal Option member, to PPL.

7. The Personal Attendant Agency **must** notify the appropriate Case Management Agency of the Service Level determination.