PERSONAL CARE SERVICES PROGRAM
REQUEST FOR DISCONTINUATION OF SERVICE

Attach this form and supporting documentation to the Member's Record in PC UMC web portal and request discharge by changing member's eligibility status in the UMC web portal.

Date: _____

Member Information:

Last Name: _____ First Name: _____

Street Address: _____

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

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

Medicaid Number: _____

Representative information (if applicable):

Name/Type of Representative_____ 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 or documentation where two witnesses accepted verbal request for closure of PC services.

☐ Member has not accessed PC services for 30 days: Unless in a facility.

☐ 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 OA, a notification of discontinuation of services will be mailed to the Member.

Form Effective 1-1-18