PERSONAL CARE SERVICES PROGRAM
REQUEST FOR SERVICE LEVEL CHANGE

PC SERVICES MEMBER INFORMATION:

Name: ________________________________Birth date: ________________ Medicaid # _______________

Street Address: _______________________________City: ______________State: _____ Zip: __________

County: _____________________________________

Legal Representative, if applicable:______________________________Phone:______________________

Member/ Legal Representative Signature: ____

Current PAS Date: ____

AGENCY INFORMATION:

Agency Name: ____

Street Address: _______________________________City: ______________State: _____ Zip: __________

Phone: ______________________________________Fax: ______________

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RN Signature Date

REQUIRED DATA TO ATTACH IN THE WEB PORTAL WITH THIS FORM:
☐ A completed copy of this cover sheet with original signatures
☐ A narrative explaining the need for Service Level change.
☐ A statement from physician, nurse practitioner or physician's assistant explaining the need for Service Level change.
☐ Current PC PAS.
☐ Current Plan of Care (POC).
☐ Proposed POC Update
☐ Any additional documentation that substantiates the request.

Upload all required documents and submit Level of Care Change Request in the UMC web portal.

Form Effective 1-1-18