

PERSONAL CARE REQUEST FOR DISCONTINUATION OF SERVICE

Attach this form and supporting documentation to the Member's Record in PC CareConnection®

Date: _____

Member 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:

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

___ Persistent 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 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 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.

