

# PERSONAL CARE REQUEST FOR DISCONTINUATION OF SERVICE

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Attach this form and supporting documentation to the Member's Record in PC CareConnection® and fax to the OA at 304-558-6647.

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 Member.

