

**PERSONAL CARE**  
***Request for Discontinuation of Services***

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**Date:** \_\_\_\_\_

**Submit all requests to:**  
**WV Bureau of Senior Services**  
**1900 Kanawha Blvd., East**  
**Charleston WV 25305-0160**  
**Fax: 304-558-6647**

Member Name: \_\_\_\_\_

Member Legal Representative: \_\_\_\_\_  
(Note N/A if not applicable)

**Address:**

Street:	City:	Zip Code	County:
Medicaid Number (11 digit number) _____		Phone Number: Home: _____ Cell: _____	

**REASON FOR REQUEST:**

- No Services have been provided for 180 continuous dates: **must note date of last service**\_\_\_\_\_.
- Unsafe Environment: **must attach documentation to support request for closure.**
- Member Noncompliant with Program: **must attach documentation to support request for closure.**
- Member No Longer Desires Services: **must attach member's written request with signature.**

Requesting Agency: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Person Making Request: Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ 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 and a copy to the Personal Care Provider.