

**AGED AND DISABLED WAIVER
REQUEST FOR SERVICE LEVEL CHANGE**

ADW PARTICIPANT INFORMATION:

Name: _____ Birth date: ___/___/___ Medicaid # _____

Street Address: _____ City: _____ State: _____ Zip: _____

County: _____

Legal Representative, if applicable: _____ Phone: _____

Participant/ Legal Representative Signature: _____

Current PAS Date: _____

AGENCY INFORMATION:

Agency Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

RN

Date

REQUIRED DATA MUST BE SUBMITTED 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 ADW PAS.
- Current Service Plan with Personal Attendant Log
- Proposed PAL Update
- Any additional documentation that substantiates the request.

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Send all required documents to: APS Healthcare, 100 Capitol Street, Suite 600, Charleston, WV 25301.
Fax: 866-212-5053.