

Date: ___/___/_____

SUBMIT ALL REQUESTS TO:

Mail: APS Healthcare, Inc.
100 Capitol Street, Suite 600
Charleston, WV 25301

Fax: 866.607.9903

Participant Information:

Name _____

Legal Representative if applicable _____

Address _____

Medicaid Number _____ Phone () _____-

REASON FOR REQUEST:

- No Services have been provided for 180 continuous days.
Date of last service ___/___/_____ (required)
- Unsafe Environment: must attach documentation to support request for closure.
- Participant No Longer Desires Services: must attach a signed written request completed by the program participant and/or legal representative.

Requesting Entity _____

Address _____

Mailing Address _____

Phone () _____-_____ Fax () _____-

Printed Name of Person Making Request

Signature of Person Making Request

Title

Date

Note: If the request is approved by APS Healthcare, Inc., a notification of discontinuation of services will be mailed to the program participant (or legal representative) and a copy to the Case Management Agency, Personal Attendant Agency and PPL (if applicable).