AGED AND DISABLED WAIVER
REQUEST FOR DISCONTINUATION OF SERVICE

Attach this form and supporting documentation to the member's record in CareConnection

1. **Date:** _____

2. **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: _____

3. **REASON FOR REQUEST:**

___ No Services have been provided for 180 continuous days. Date of last service _____ (required).

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

___ Member Non-compliance with program: must attach supporting documentation with request for closure.

___ Member no longer desires services: must attach member's written request with signature.

___ Member no longer requires services: must attach supporting documentation with request for closure.

___ Member moved out of state: must attach supporting documentation with request for closure.

___ ADW services are no longer sufficient to safely maintain the ADW member in a home setting.

4. **Requesting Agency**: _____

Phone: _____

5. **Other ADW Provider (PA or CM Agency)**: _____

Phone: _____

6. _____ Email: _____
Printed Name of Person Making Request Email of Person Making Request

_____ _____ _____
Signature of Person Making Request Title Date

NOTE: If the request is approved by the OA, a notification of discontinuation of services will be mailed to the Member. A copy of the notice will be sent to the agency that requested the discharge.