AGED AND DISABLED WAIVER
REQUEST FOR SERVICE LEVEL INCREASE

1. .SERVICE LEVEL REQUEST TYPE:

☐ Change in Condition

☐ Start New Service Level prior to Anchor Date with recent PAS

NOTE: If requesting to start a new Service Level prior to the Anchor Date, please fax/email completed Service Level Change form to the UMC. Member/Legal Representative signature is not required. (See page two for required documentation.)

2. ADW MEMBER INFORMATION:

Last Name:_____ First Name:_____

Birth date:_____ Medicaid #:_____

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

County:_____

Legal Representative, if applicable:_____Phone:_____

Member / Legal Representative Signature:_____

Current PAS Date:_____

3. AGENCY INFORMATION:

Agency Name:_____

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

Phone:_____ Fax:_____

_____ _____

CM or RN Signature Date

_____ _____

Member Signature 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. **This statement must be on medical office letterhead.** • Current ADW PAS. • Current Service Plan with Personal Attendant Log • Proposed PAL Update • Any additional documentation that substantiates the request.

Send all required documents to: KEPRO, 1007 Bullitt Street, Suite 200, Charleston, WV 25301.

Fax: 866-212-5053.