State Plan Personal Care Communication

Member Information

Member last name ______ First name ______ Middle initial ______ County ______ Case number ______

Provider agency ______ Date form completed ______ Client Identification number ______

Recommended Changes or Communication

Check appropriate change:

- ◯ Address or phone number change
- ◯ Provider agency closure
- ◯ Change of provider agency
- ◯ Decrease in services
- ◯ Increase in services
- ◯ (DHS use only) Terminate personal care services
- ◯ Other
- ◯ Recommend termination of Personal Care services
- ◯ Resume services
- ◯ Suspend services
- ◯ Staffing issues
- ◯ Unstaffed for 30 calendar days

Number of current unit(s) per week: ______ Recommended unit(s) per week ______

Justification or Comments

Signature

Name and title of person completing form ______ Contact number ______

Signature ______ Date ______