

EDWP NOTIFICATION FORM

1. Mark (X) indicate the reason for sending: (CC to Provider ☐ Provider to CC ☐)

☐ Initial ☐ Change ☐ Complaint/Concern ☐ Transfer ☐ Discharge ☐ Other

2. To: Date:

3. From: Telephone:

4. Client Name: (Source ☐ CCSP ☐) Medicaid #:

☐ Mark if new address Client Address:

City: Zip: County: Telephone:

5. SERVICES:

☐ PSS ☐ PSSX ☐ CD PSS ☐ SFC
☐ ERS
☐ ALS
☐ ADH ☐ HALF, ☐ FULL ☐ LEVEL I, ☐ LEVEL II
☐ HDM
☐ SNS ☐ RN, ☐ LPN
☐ HDS
☐ OHR

COMMENTS:

6. Date your RN/Staff completed initial evaluation with client: (Must be RN for ALS, ADH and PSS/X)

☐ Services were accepted ☐ Services were not accepted – REASON:

7. Date services began:

8. Service Issues: (Check below and clarify in #14)

Request service increase ☐
 Failure to pay cost share ☐
 Client termination ☐
 Health/Safety Issue ☐
 Client out of home ☐

Request service decrease ☐
 Fall/Incident ☐
 Requested provider change ☐
 Request for information ☐
 Other ☐

9. Discharge (briefly describe actions leading up to need for discharge process):

10. Date discharge (30-day) letter sent Actual discharge date Last day of service

11. Are services continuing through 30-day notice? ☐ Yes ☐ No Please enter final units below

FINAL UNITS PSS PSSX CD PSS SFC ADH ERS
 HDM ALS RN LPN OHR

12. INITIAL OR CURRENT SERVICES IN THE HOME:

13. FREQUENCY CHANGES REQUESTED:

14. **Complaint/Concern/Other**

15. ER/Hospital/Rehab visit- (Name/Date/Reason if known)

16. Sender name or signature: Title: Date: Email:

17. Recipient name or signature: Title: Date: Email:

18. Recipient response: