**EDWP NOTIFICATION FORM**

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

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

1. **To:** **Date:**
2. **From:** **Telephone:**

1. **Client Name:** **(Source  CCSP  ) Medicaid #:**

**Mark if new address Client Address:**

**City:** **Zip:** **County:** **Telephone:**

1. **SERVICES:**

**PSS**  **PSSX  CD PSS  SFC**

**ERS**

**ALS**

**ADH**  HALF, FULLLEVEL I,  LEVEL II

**HDM**

**SNS**  RN,  LPN

**HDS**

**OHR**

**COMMENTS:**

1. **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:**

1. **Date services began:**
2. **Service Issues: (Check below and clarify in #14)**

**Request service increase  Request service decrease**

**Failure to pay cost share**  **Fall/Incident**

**Client termination**  **Requested provider change**

**Health/Safety Issue**  **Request for information**

**Client out of home  Other**

1. **Discharge (briefly describe actions leading up to need for discharge process):**
2. **Date discharge (30-day) letter sent** **Actual discharge date** **Last day of service**
3. **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**

1. **INITIAL OR CURRENT SERVICES IN THE HOME:**
2. **FREQUENCY CHANGES REQUESTED:**
3. **Complaint/Concern/Other**
4. **ER/Hospital/Rehab visit- (Name****/Date/Reason if known)**
5. **Sender name or signature:** **Title:** **Date:** **Email:**
6. **Recipient name or signature:** **Title:** **Date:** **Email:**
7. **Recipient response:**

**Revised** 11/19