**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, [ ] FULL[ ] LEVEL 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:**

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