**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 all applicable below and clarify in #13)***

**Request for service increase  Request for service decrease**

**Failure to pay cost share**  **Client out of home**

**Services initiated  Client termination**

**Requested provider change**  **Health/Safety Issue**

**Request for information**  **Missed Visit(s)**

**Admission to Rehab/NH  Request for PA info/PA update**

**Scheduled day surgery/no hospital admission**

**Other**

**(*scheduled hospital admits/overnight stay, ER visits or reports of falls require an online incident report-no form needed)***

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**
4. **Initial or current services/frequency in the home/facility:**
5. **Complaint/Concern/Other (from #8)**
6. **Sender name or signature:** **Title:** **Date:** **Email:**
7. **Recipient name or signature:** **Title:** **Date:** **Email:**
8. **Recipient response:**

**Revised** 4/21