



Home and Community-Based Services • Personal Care Services and Community First Choice Personal Care Services Request for Expedited Consideration

Applicant/Recipient

Name

Medicaid number

This request is for an [] Initial application/assessment [] Amendment of current service plan for the following program: [] IDD [] ISW [] APDD [] ALI [] PCS [] CCMC

For an initial application, provide the address of the location where an assessment can be performed:

Basis for expedited consideration

The recipient has no natural supports able to meet his /her needs, and qualifies for expedited consideration because of

- [] a diagnosis of terminal illness with a life expectancy of six months or less
[] imminent/recent discharge on from an acute care or nursing facility
[] unplanned absence of primary unpaid caregiver due to medical/family emergency or hospitalization
[] declining health of his/her primary unpaid caregiver
[] the death of his/her primary unpaid caregiver on
[] Adult Protective Services/Office of Children's Services referral

For Personal Care Services only

- [] an immediate need for a time-limited increase in services related to functional capacity

Describe the circumstances that qualify the applicant/recipient for expedited consideration.

Required documentation Attach documentation that supports expedited consideration.

Provider agency requesting expedited consideration

Agency name

Provider number

Agency contact

Phone number

DSM/encrypted Email address

Agency FAX number

Agency representative signature

Date

For SDS use only Date of review Request [] approved [] denied

Reason for decision

[] Follow-up on Purpose

SDS reviewer signature

Date