



Home and Community-Based Services • 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 CCMC APDD ALI PCS

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

Telephone 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