SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: FORMS
	Subject: Agency Based Request for Case Review SLTC- MA-128

PURPOSE:

At times, a provider may have concerns about another provider's performance in serving our members. The Request for Case Review form gives them a vehicle on which to note their concerns and forward them to the state office. Use this form with discretion.

INSTRUCTIONS:

Program: Enter the type of provider, i.e., personal assistance, home health, HCBS, etc.

Date: Enter the completion date of the form.

Recipient: If the concern involves a single member, fill in the member's name.

Medicaid ID: Enter the member's Medicaid ID number.

Reporter: Enter the reporters name and the agency's name. This field is optional.

PROVIDER

Description of Activity:

Give specific examples with dates and times whenever possible. (For example, worker left 30 minutes early Wed July 21 and Friday July 23 without explanation; or on June 3 client complained that nurse is not changing dressing as indicated in his POC).

Current Services: If the concern is for a specific member, indicate all the services the member is receiving. otherwise enter N/A.

Concern: Clearly state the concern. This means what could result from what is happening. Such as, member not receiving allocated hours, Member's health is at risk because wound is not being cared for properly.

Resolved: If the agency and has been contacted and the issue is resolved, check the yes box. If not, check the no box.

Forward all copies to the Senior and Long Term Care Division.

DPHHS: The program manager will complete this section.

DISTRIBUTION

White copy – Provider Agency
Yellow – DPHHS – SLTC*
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