SECTION
PROGRAM DESCRIPTION

SUBJECT
Request for Case Review

PURPOSE

At times, providers are seriously concerned about another provider's performance in serving our clients. The Request for Case Review form (Refer to DPHHS-MA-128) gives them a vehicle on which to note their concerns and forward them to the state office. Use this form with discretion.

Program --Enter the type of provider you are concerned about, i.e., personal assistance, home health, HCBS, etc.

Date--Enter the date on which you are completing the form.

Recipient--If your concern involves a single individual, fill in the individual's name.

Medicaid ID--Enter the individual's Medicaid ID number.

Reporter--Enter your name and agency. This field is optional.

PROVIDER

Describe what is happening--Give specific examples with dates and times whenever possible. For example, "worker left 30 minutes early Wednesday, July 21 and Friday, July 23 without explanation"; or, "on June 3 individual complained that nurse is not changing dressing as indicated in his POC."

Services in place--If your concern is for a specific individual, indicate all the services the individual is receiving. Otherwise write N/A.

Concern--Clearly state your concern. This means what could result from what is happening. For example, "individual not receiving allocated hours"; or, "individual's health is at risk because wound is not being cared for properly."

Resolved--If you have contacted the agency and have been able to resolve this issue, check the yes box. If not, check the no box.

Forward all copies to the Addictive and Mental Disorders Division to the attention of the program manager responsible for the service you are concerned about.

DPHHS

The program manager will complete this section.