REGION IV AREA AGENCY ON AGING Fax #: (269) 983-5218

FAX

NOTIFICATION OF NON-SERVICE
CARE MANAGEMENT/MI CHOICE WAIVER

TO: _____
Care Manager

FROM: _____
Provider

PARTICIPANT: _____ SSN (last 4 digits) _____

PROGRAM TYPE:
- ☐ MI Choice Waiver
- ☐ Care Coordination
- ☐ Self-Determination
- ☐ Care Management
- ☐ Caregiver Respite
- ☐ Residential Services

We ☐were unable or ☐will be unable to provide the following service(s):

Service	# of Units per Service	Date(s) & Time(s) of Service
☐ Adult Day Care	_____	_____
☐ Chore	_____	_____
☐ Community Living Supports	_____	_____
☐ Counseling	_____	_____
☐ Home Delivered Meals	_____	_____
☐ Homemaker	_____	_____
☐ In-Home Respite	_____	_____
☐ PDN	_____	_____
☐ Personal Care	_____	_____
☐ Residential Service	_____	_____
☐ Transportation	_____	_____

Reason:
- ☐ PNA (Participant Not Available)
- ☐ PC (Participant Cancelled)
- ☐ PS (Participant Sick)
- ☐ PH (Participant Hospitalized)
- ☐ PNF (Participant in Nursing Facility)
- ☐ PDH (Participant Decreased Hours)
- ☐ PRW (Participant Refused Worker)
- ☐ VNS (Vendor/Worker No Show)
- ☐ VS (Vendor/Worker Sick)
- ☐ VSP (Vendor/Worker Scheduling Problems)
- ☐ VNA (Vendor Worker Not Available)
- ☐ VIW (Vendor Inclement Weather)
- ☐ VH (Vendor Holiday)

☐ A substitute worker was offered and refused by the participant because (explain below).

☐This ☐is ☐was a temporary situation and staffing will resume.
☐This is a permanent situation and we can no longer provide staffing. **
** this requires a direct contact call to Care Manager and provision of 5-10 business day notice per contract requirements depending on Priority Rating.

Comments/Explanation: _____

_____ _____
Provider Staff Signature Date Sent

The purpose of this form is for quality assurance to ensure services are delivered to Care Management/MI Choice Waiver clients as outlined in their Plan of Care.