Form 148W - Withdrawal, Discharge, or Death Notice (Permanent Discharges Only)

Support Coordinator Agency

Name: _____ Medicaid Provider #: _____

Address: _____

Telephone #: _____ Fax #: _____ E-Mail: _____

Participant

Update Personal Information, effective: _____

Name: _____ SSN: _____

Address: _____

Region: _____ Sex: _____

Parish: _____ Medicare #: _____

DOB: _____ Marital Status: _____ Phone #: _____

Medicaid Eligible: _____ Medicaid #: _____

Waiver Type: _____

Personal Representative / Curator

Name: _____ Relationship: _____

Address: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Day Phone: _____

Discharge Information

A. Discharge

Discharge Date: _____

Reason: _____

Discharge To: _____

B. Withdrawal / Declined / Inactive - Waiver Services Requested

Type: _____

Date: _____

C. Death

Date of Death: _____

Created By: Date Created: