

EDWP NOTIFICATION FORM

1. Mark (X) indicate the reason for sending: (CC to Provider ☒ Provider to CC ☐)

☐ Initial ☒ Change ☐ Complaint/Concern ☐ Transfer ☐ Discharge ☒ Other

2. To: Verification Manager

3. From: 24 Hours home care

4. Client Name: Long Notes Verification Client (Source ☒ CCSP ☐) Medicaid #: 123456789

☐ Mark if new address Client Address: 123 Verification Avenue

City: Atlanta Zip: 30303 County: Fulton Telephone: (404) 555-0101 ☐ New Number

5. SERVICES:

COMMENTS:

6. Date your RN/Staff completed initial evaluation with client: 08/20/2026

☒ Services were accepted ☐ Services were not accepted

- REASON:

7. Date services began: 08/21/2026

8. Service Issues: *(Check all applicable below and clarify in #13)*

Request for service increase	☐	Request for service decrease	☐
Failure to pay cost share	☐	Client out of home	☐
Services initiated	☐	Client termination	☐
Requested provider change	☐	Health/Safety Issue	☐
Request for information	☒	Missed Visit(s)	☐
Admission to Rehab/NH	☐	Request for PA info/PA update	☐
Scheduled day surgery/no hospital admission	☐		
Other	☒		

(scheduled hospital admits/overnight stay, ER visits or reports of falls require an online incident report-no form needed)

9. Discharge (briefly describe actions leading up to need for discharge process):

Revised : 4/2021