Texas Department of Aging
and Disability Services

Form 1025
June 2011-E

Request for Information

Medicare Advantage Coordination

To: _____

_____

_____

Mail Code	Fax Area Code and No.

From: _____

_____

_____

Mail Code	Fax Area Code and No.

This is a request for verification of Department of Aging and Disability Services (DADS) Community Services received by the individual:

Individual Name	Medicaid No.	Social Security No.
Address (Street, City, State, ZIP Code)		
Area Code and Telephone No.	County	Date of Birth

_____ Signature - Requestor

_____ Date

For DADS Use Only:

The above named individual receives the Community Services checked below.

- ☐ In-Home and Family Support Services (IHFSP)
- ☐ Medically Dependent Children Program (MDCP)
- ☐ Primary Home Care (PHC)
- ☐ Community Attendant Services (CAS)
- ☐ Family Care (FC)
- ☐ Home Delivered Meals (HDM)
- ☐ Emergency Response Services (ERS)
- ☐ Special Services to Persons with Disabilities (SSPD)
- ☐ Adult Foster Care (AFC)
- ☐ Assisted Living/Residential Care (AL/RC)
- ☐ Other: _____
- ☐ STAR+PLUS

  Name of STAR+PLUS Plan member is enrolled in:

  _____

  Plan contact's area code and telephone no.:

  _____
- ☐ Community Based Alternatives Waiver (CBA)

  Name of Home and Community Support Services Agency (HCSSA):

  _____

  HCSSA contact's area code and telephone no.:

  _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ The above named individual is currently in a nursing facility but requests to resume services in the community.

Service Delivery Area Relocation Coordinator:

Name		Area Code and Telephone No.
_____ Signature – DAD's Staff	_____ Date	_____ Area Code and Telephone No.

Response:

To: _____

_____

_____

Mail Code	Fax Area Code and No.

From: _____

_____

_____

Mail Code	Fax Area Code and No.