



STATUS CHANGE FORM

Name: _____ **Effective Date of Change:** _____

EIN Holder (if applicable): _____

Service Recipient (Client, Consumer, Member) Managing Party (PR, LR, DR) Employee/Caregiver

Instructions: Please mark the boxes that apply and fill in the new information. Provide supporting documentation if indicated.

| Local Office Changes | | |
|--|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Address Change <div style="text-align: right; margin-top: 5px;">New Address City, State Zip</div> | <input type="checkbox"/> Mailing | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Phone Number Change <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell | New Phone Number: _____ | |

| Local Office Plus CDMS Changes | |
|--|--|
| <input type="checkbox"/> Name Change <small>*provide supporting documentation (Social Security Card) with this form</small> | Previous name: _____ New name: _____ |
| <input type="checkbox"/> Social Security Number Change <small>*provide supporting documentation (Social Security Card) with this form</small> | Previous SSN: _____ New SSN: _____ |
| <input type="checkbox"/> Date of Birth Change <small>*provide supporting documentation with this form</small> | Previous DOB: _____ New DOB: _____ |
| <input type="checkbox"/> New EIN Holder <small>*requires supporting paperwork – contact your coordinator</small> | New EIN Holder: _____ |
| <input type="checkbox"/> Caregiver Payment Type Changes <small>*requires supporting paperwork – completed pay selection form</small> | <input type="checkbox"/> Add Pay Card <input type="checkbox"/> Cancel Pay Card <input type="checkbox"/> Change Direct Deposit <input type="checkbox"/> Add Direct Deposit <input type="checkbox"/> Cancel Direct Deposit <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Caregiver Wage Changes <small>*requires paperwork and approval – contact your coordinator</small> | Service Recipient Name: _____ New Wage: _____ Service Code(s): _____ <input type="checkbox"/> New Modified Wage Agmt <input type="checkbox"/> Change MWA <input type="checkbox"/> End MWA |
| Service Recipient – <input type="checkbox"/> Reactivation <input type="checkbox"/> Deactivation <input type="checkbox"/> Hold <input type="checkbox"/> Transfer <small>* change in Auth requires supporting paperwork</small> | Explanation: _____ <input type="checkbox"/> Reactivate for billing purposes only |
| Employee/Caregiver – <input type="checkbox"/> Reactivation <input type="checkbox"/> Dismissal or <input type="checkbox"/> Hold <small>*if Dismissal, from <input type="checkbox"/> Company or <input type="checkbox"/> Individual Service Recipient</small> <small>*reactivation requires supporting documentation</small> | Service Recipient Name: _____ Who terminated the Employee/Caregiver: <input type="checkbox"/> Resigned <input type="checkbox"/> Service Recipient <input type="checkbox"/> Unknown Was a two week notice given: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Explanation: _____ |
| <input type="checkbox"/> Employee/Caregiver Location Change | Previous location: _____ New location: _____ |
| <input type="checkbox"/> Other/Additional Information: <div style="height: 40px;"></div> | |

Service Recipient, Managing Party, or Employee Signature

Date

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