CONSUMER DIRECT CARE NETWORK

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			
☐ **Address Change**	Mailing (City, State, Zip):		
	Physical (City, State, Zip):		
☐ **Phone Number Change**	Home:	Work:	Cell:

Local Office Plus CDMS Changes		
☐ **Name Change** *provide supporting documentation (Social Security Card) with this form	Previous name: New name:	
☐ **Social Security Number Change** *provide supporting documentation (Social Security Card) with this form	Previous SSN: New SSN:	
☐ **Date of Birth Change** *provide supporting documentation with this form	Previous DOB: New DOB:	
☐ **New EIN Holder** *requires supporting paperwork – contact your coordinator	New EIN Holder:	
☐ **Caregiver Payment Type Changes** * requires supporting paperwork – completed pay selection form	☐ Add Pay Card ☐ Cancel Pay Card ☐ Change Direct Deposit ☐ Add Direct Deposit ☐ Cancel Direct Deposit ☐ Other:	
☐ **Caregiver Wage Changes** * requires paperwork and approval – contact your coordinator	Service Recipient Name: Service Code(s):	New Wage: ☐ New Mod Wage Agrmt ☐ Change Mod Wage Agrmt ☐ End Mod Wage Agrmt
Service Recipient – ☐ **Reactivation** ☐ **Deactivation** ☐ **Hold** ☐ **Transfer** * change in Auth requires supporting paperwork	Explanation: ☐ Reactivate for billing purposes only	
Employee/Caregiver – ☐ **Reactivation** ☐ **Dismissal** ☐ **Hold** *if **Dismissal**, from ☐ Company or ☐ Individual Service Recipient ***reactivation** requires supporting documentation	Service Recipient Name: Who terminated Employee/Caregiver: ☐ Resigned ☐ Service Recipient ☐ Unknown Was a two week notice given: ☐ Yes ☐ No Explanation:	
☐ **Employee/Caregiver Location Change**	Previous location:	New location:

Other/Additional Information:

_____ _____

Service Recipient, Managing Party, or Employee Signature Date

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