This form is intended to notify service delivery teams (Area Agencies, Service Coordinators, and Direct Service providers of Residential, Day Habilitation) of changes to certain aspects of an individual's services or personal information. This form must be used to notify Service Coordinators and Area Agencies of a status change for individuals receiving any services through the Home and Community-Based Care Waiver. For transferring services, the new agency is responsible for notifying the team of the changed service. For ending services, the last rendering provider is responsible for notification to the team.

**Only areas where there is a change in information should be filled out, not the entire form. The notifying entity must send this to the individual’s team (Service Coordinator, Area Agency, and Direct Service Provider) ASAP but no more than 2 business days past finding out about change.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual Name:** | | | | **DOB:** | |
| **Medicaid Number:** | | | | **Area Agency:** | |
| **Form to be sent to:** Service Coordinator *(email)*:      ; Service Provider(s) *(email)*: | | | | | |
| **Waiver:**  **DD**  **ABD**  **IHS**  **CFI**  **Non-waiver** | | | | | **Out of State Provider?** |
| *NOTE: All areas in the sections above must be filled out completely with every form submission.* | | | | | |
| **Personal Information** | | | | | |
| *Date of Change* | *Status Update* | | | | |
|  | Managed Care Organization: | | | | |
|  | Medicaid Status Change:  Open  Closed Reason: | | | | |
|  | Gender at Birth:       Chosen gender:  Is this a legal change?  Yes  No | | | | |
|  | Name Change:       Is this a legal change?  Yes  No | | | | |
|  | Physical Address: | | | | |
|  | Mailing Address: | | | | |
|  | Phone Number:        Cell  Home  Work  Other | | | | |
|  | New Diagnosis(es): | | | | |
|  | Diagnosis(es) removed: | | | | |
|  | Email Address: | | | | |
|  | Deceased, Cause of Death: | | | | |
|  | Other/Notes: | | | | |
| **Immediate Family** | | | | | |
| *Date of Change* | *Status Update* | | | | |
|  | Name: | | | | |
|  | Relationship: | Email: | | | |
|  | Phone Number:        Cell  Home  Work  Other | | | | |
|  | Address: | | | | |
|  | Other/Notes (Including individual preference regarding contact): | | | | |
|  | Name: | | | | |
|  | Relationship: | Email: | | | |
|  | Phone Number:        Cell  Home  Work  Other | | | | |
|  | Address: | | | | |
|  | Other/Notes (Including individual preference regarding contact): | | | | |
| **Guardianship Information** | | | | | |
| *Date of Change* | *Status Update* | | | | |
|  | Guardian appointment:  None  New  Change  Termination | | | | |
|  | Type of guardianship (*Include documentation, select one*):  Person  Estate  Person & Estate  Minor Other/Notes: | | | | |
|  | Guardian name:        Family  Private  Public | | | | |
|  | Guardian Physical Address: | | | | |
|  | Guardian Mailing Address: | | | | |
|  | Guardian Phone Number:        Cell  Home  Work  Other | | | | |
|  | Guardian Phone Number:        Cell  Home  Work  Other | | | | |
|  | Guardian Email: | | | | |
|  | Co-guardian name:        Family  Private  Public | | | | |
|  | Co-guardian Physical Address: | | | | |
|  | Co-guardian Mailing Address: | | | | |
|  | Co-Guardian Phone Number:        Cell  Home  Work  Other | | | | |
|  | Co-Guardian Phone Number:        Cell  Home  Work  Other | | | | |
|  | Co-Guardian email: | | | | |
|  | Power of Attorney (include documentation): | | | | |
|  | POA Phone/Email: | | | | |
|  | Supported Decision Maker(s): | | | | |
|  | SDM Phone/Email: | | | | |
|  | Other/Notes: | | | | |
| **Service Delivery Information** | | | | | |
| *Date of Change* | *Status Update* | | | | |
|  | Area Agency:  New  Transfer from: | | | | |
|  | Service Coordination Agency: | | | | |
|  | Service Coordinator: | | | | |
|  | Service Coordinator email: | | | | |
|  | Service Coordinator Phone Number: | | | | |
|  | New to services  Returning to services Notes: | | | | |
|  | Type of service:  Traditional  Self Directed, PDMS  Self Directed, IHS | | | | |
|  | Type of residence:  Lives with family  Lives Independently  Enhanced Family Care  Staffed Residence  Waivered Respite  Other: | | | | |
|  | HRST:  Add  Delete  Inactive | | | | |
|  | Withdrawal from Provider Agency:       Reason: | | | | |
|  | Withdrawal from services *(check all that apply)*:  CPS  CSS  Residential  SEP  PDMS  IHS  Other/Notes *(list specific services within PDMS/IHS if applicable)*: | | | | |
|  | Termination from all waiver services. Details: | | | | |
|  | Person has been admitted to hospital or rehab center, name: | | | | |
|  | Waiver change: Will begin using DD ABD  IHS CFI waiver | | | | |
|  | Waiver change: Will discontinue using DD ABD  IHS CFI waiver | | | | |
|  | Activation of crisis policy, describe (ex. when the SC determines a need to pull the crisis team together, identifies need to utilize crisis funding, etc.):  Date BDS was notified of crisis: | | | | |
|  | Other/Notes: | | | | |
| **Provider Agency Information** | | | | | |
| *Date of Change* | *Status Update* | | | | |
|  | New Provider Agency:       Certification type and number:  Service:  CSS  CPS  SEP  RES  SSL Other:  Phone:       Email:       Contact Person: | | | | |
|  | New Provider Agency:       Certification type and number:  Service:  CSS  CPS  SEP  RES  SSL Other:  Phone:       Email:       Contact Person: | | | | |
|  | New Provider Agency:       Certification type and number:  Service:  CSS  CPS  SEP  RES  SSL Other:  Phone:       Email:       Contact Person: | | | | |
|  | Provider Agency Removed:       Type of Service:  Remove from HRST?  Yes  No | | | | |
|  | Provider Agency Removed:       Type of Service:  Remove from HRST?  Yes  No | | | | |
|  | Other new contacts for file, include name/role/contact info: | | | | |
|  | Remove the following contacts from file: | | | | |
|  | Other/Notes: | | | | |
| **Benefits Information** | | | | | |
| *Date of Change* | *Status Update* | | | | |
|  | Rep Payee name: | | | | |
|  | Rep Payee Phone:       Rep Payee Email: | | | | |
|  | Medicare or other insurance number: | | | | |
|  | Benefit Status Change: | | | | |
| SSI:  Open  Closed Date: | | APTD:  Open  Closed Date: | | | |
| SSDI:  Open  Closed Date: | | MEAD:  Open  Closed Date: | | | |
|  | Cost of Care:  Yes  No Amount: | | | | |
|  | Special Needs Trust:  Yes  No | | | | |
|  | Special Needs Trust Contact Person:       Phone:       Email: | | | | |
|  | Other/Notes: | | | | |
| **Other Notes, please include date of note** | | | | | |
|  | | | | | |
| Updated by:       Date: | | | | | |
| Sent to: | | | | | |
| Service Coordinator:       Date: | | | | | |
| Provider Agency:       Date: | | | | | |
| Area Agency (check one): | | | | | |
| 1: Northern Human Services - [NHS-ProviderAgencyEmail@northernhs.org](mailto:NHS-ProviderAgencyEmail@northernhs.org) | | | 6: Gateways – [ChangeNotification@gatewayscs.org](mailto:ChangeNotification@gatewayscs.org) | | |
| 2: Pathways - [changenotification@pathwaysnh.org](mailto:changenotification@pathwaysnh.org) | | | 7: Moore Center - [R7StatusChange@moorecenter.org](mailto:R7StatusChange@moorecenter.org) | | |
| 3: Lakes Region Comm Svcs - [StatusChange@lrcs.org](mailto:StatusChange@lrcs.org) | | | 8: One Sky - [VendorEmail@oneskyservices.org](mailto:VendorEmail@oneskyservices.org) | | |
| 4: Community Bridges - [StatusChange@cbinnh.org](mailto:StatusChange@cbinnh.org) | | | 9: Community Partners - [changenotification@communitypartnersnh.org](mailto:changenotification@communitypartnersnh.org) | | |
| 5: Monadnock Developmental Svcs - [changenotification@mds-nh.org](mailto:changenotification@mds-nh.org) | | | 10: Community Crossroads - [StatusChange@communitycrossroadsnh.org](mailto:StatusChange@communitycrossroadsnh.org) | | |
| Bureau of Developmental Services:       Date: | | | | | |
|  | | | | | |

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