REQUEST FOR SIGNIFICANT CHANGE

Name of person receiving services:
Medicaid #:
Person submitting request (Case Manager Name):
Date Submitted:

Case Management Provider (CM):
Community Support Provider (CSP):

Is this an enhanced rate? Yes ☐ No ☐

☐ **Add Residential** **Change Service:** ☐ **End Service:** ☐
Funding: Choose an item.
Ownership:
Room and Board Funding:

Former Street Address: County: Type of Residential service: Choose an item. Capacity change From: To: Does this create a capacity change in former address: ☐Yes ☐No If yes, please describe and attach names of all people affected by change: End Date:
New Street Address: County: Type of Residential service: Choose an item. Capacity change From: To: Does this create a capacity change in new address: ☐Yes ☐No If yes, please describe and attach names of all people affected by change: Start date:

☐ **Add Day Hours (Segregated)** **Decrease:** ☐ **End Service:** ☐
Category: Choose an item.
Non Paid Activities: Choose an item.
Paid Employment: Choose an item.
Funding: Choose an item.

Number of previous non-paid hours:	Number of new non-paid hours :
Number of previous paid hours:	Number of new paid hours:
Total number of Previous hours:	Total number of new hours:
Previous wage per hour:	New wage per hour:
End date:	Start Date:

☐ **Add Supported Employment** **Decrease:** ☐ **End Service:** ☐
Category: Choose an item.
Setting: Choose an item.
Type of Paid Employment: Choose an item.
Wage Payer: Choose an item.
Funding: Choose an item.

Number of previous hours:	Number of new hours:
Previous wage per hour:	New wage per hour:
End Date:	Start Date:

☐ **Add Prevocational** **Decrease:** ☐ **End Service:** ☐
Type of Paid Employment: Choose an item.
Funding: Choose an item.

Total number of Previous hours:	Total number of new hours:
Previous wage per hour:	New wage per hour:
End date:	Start Date:

☐ **Other Services**
Funding: Choose an item.

☐ Speech, Hearing & Language	☐ Medical Equipment and Drugs	☐ Other Medical
Start Date:	Start Date:	Start Date:
End Date:	End Date:	End Date:

☐ **ICAP (*If there is an ICAP change and service change with different start/end dates, two SCRs must be completed)*- ICAP booklet must be sent with change in this area.**

Does the participant & guardian (if applicable) agree?
Summary of why the services are being changed (Required Area):

Notice of Reduction of Services ARSD 46:11:08:04:		
Was the participant/guardian notified in writing of the intent to reduce services? ARSD	☐ **Yes** **Date:** ☐ **No**	☐ **N/A (Explain):**
Was the participant/guardian notified of the right to appeal the reduction in services?	☐ **Yes** ☐ **No**	☐ **N/A (Explain):**

SCR APPROVAL

Current CSP: ____ ____________
Signature/ Title **Date**

Current CM: ____ ____ ____________
Signature/ Title **Date**

For DDD use only. **Rate Information:** Current Rate: New Rate: Difference in Rate:		☐ Changes Verified	
Date Rec'd / Processed and Initials	Entered in Tracking	Action	Comments