REQUEST FOR PROVIDER CHANGE

Name of person receiving services:
Medicaid #:
Person submitting request (Case Manager name):
Case Management Provider:
Community Support Provider:
Date Submitted:
Does this participant have an enhanced rate? Yes ☐ No ☐

☐ **Change Case Management Provider**
Funding: Choose an item.

Former Case Management Provider:	**New Case Management Provider:**
End Date:	**Start Date:**

☐ **Change Community Support Provider**
Funding: Choose an item.

Former Community Support Provider:	**New Community Support Provider:**
End Date:	**Start Date:**

Services the participant will receive at the new CSP

Residential Services (address is required even if residential supports are not provided)
Funding: **Ownership:**
Room and Board Funding:

Street Address: County: Type of Residential service: Choose an item. What is the capacity? 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:

Day Hours (Segregated)
Category: Choose an item. **Non Paid Activities:** Choose an item.
Paid Employment: Choose an item. **Funding:** Choose an item.

Number of non-paid hours :
Number of paid hours:
Total number of hours:
Wage per hour:
Start Date:

Supported Employment
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 hours:
Wage per hour:
Start Date:

Prevocational
Type of Paid Employment: Choose an item. Funding: Choose an item.

Number of non-paid hours :
Number of paid hours:
Total number of hours:
Wage per hour:

Start Date:

Other Services
Funding:

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

☐ **ICAP**

Does the participant & guardian (if applicable) agree? Yes ☐ No ☐
Summary of why the provider is being changed:

SCR APPROVAL

New/Current CSP: ______________________________ ____________
Signature/ Title **Date**

New/Current CM: ______________________________ ____________
Signature/ Title **Date**

***Former CSP:** ______________________________ ____________
Signature/ Title **Date**

***Former CM:** ______________________________ ____________
Signature/Title **Date**

***Only need signature of former CSP or former CM if providers are being changed**.

	Signature	Date
PS of the new CSP reviewed the SCR		
PS completed a Change in HCBS 730		
PS provides copy of 730 and 814 to Sr Secretary		
Sr Secretary submitted 730 to DSS		
Sr Secretary updated ICAP database		
Sr Secretary submitted 814 and 730 to Financial PS		
Financial PS updated Therap and FoxPro and submitted to B&F		
B&F approved the CSA and submitted to Sr Secretary		
Sr Secretary sent CSA to the provider		