Common Law Employer and Participant Services Change Form

This form is to capture **Common Law Employer changes, service holds and terminations** from the Participant Directed Model of Service program. This form is **not** intended to support changes to Participant demographic information (name, address, etc.) or waiver type. These changes should be made in HCSIS or SAMS. The Current Vendor will receive these changes through regular data transfers provided by the Office of Long Term Living (OLTL)

Service Coordinator

Date: _____ Service Coordinator Name: _____ Phone : (_____/_____/_____

Agency: _____E-mail Address: _____

Participant Information

Medicaid ID (10 Digit) # _____ SSN: _____ Current Vendor ID # (if known) _____

Last Name: _____ First Name: _____

Please Select the Reason for Submission:

☐ **COMMON LAW EMPLOYER CHANGE**

Last Name: _____ First Name: _____ SSN: _____

Physical Address_____

City: _____ State: _____ Zip _____ Relationship to Participant: _____

Phone: (_____)/_____/_____ Alternate Phone: (_____)/_____/_____ E-mail Address_____

Reason for Change: _____

☐ **SERVICE HOLD**

If the Participant has been admitted into a hospital, nursing facility, etc., please provide the reason for the gap in services and specify the start and end dates for the temporary hold.

Reason for Gap in Services	Effective Start Date Hold	Allow DCW to be paid for this date (check one)	Effective End Hold Date	Allow DCW to be paid for this date (check one)
		☐ Yes ☐ No		☐ Yes ☐ No

☐ **TERMINATION FROM FINANCIAL MANAGEMENT SERVICES**

Reason for Termination:

Voluntary: ☐ Deceased ☐ Entered Facility ☐ Switched to Agency Model ☐ No Longer Waiver Eligible

Involuntary: ☐ Health and Safety Concern ☐ Consistent Non-Adherence to Program Policy

☐ Not Managing the Individual Budget According to the ISP ☐ Inappropriate Utilization of Funds

☐ Other

Enrollment End Date: _____

SUBMIT FORM: Fax completed for to: Current Vendor or Email completed form to: Current Vendor

Rev 4/17