COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION
SOUTHWEST DEVELOPMENTAL SERVICES, INC.

REQUEST FOR CHANGE OF SERVICE/FUNDING

Individual's Name: _____ DOB: _____

Address:_____ City, State, Zip: _____

SS#: _____ Medicaid #: _____

HCBS TIER _____

Current Service/POC

Type of Service:	Amount of Service:	Provider:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Requested Service

Type of Service:	Amount of Service:	Provider:	Start Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Justification for any new or additional services must be submitted in writing by following the Narrative Guidelines. A copy of the current plan of care and the new plan of care with requested changes must be attached.

By signing below, I acknowledge I have been impartially informed of all the service options and service providers available within the CDDO service area and have been assisted in making an informed choice.

Consumer/Parent/Guardian Signature: _____ Date:_____

Address of person signing form: _____

Case Manager Signature: _____ Date:_____

This section to be completed by the CDDO

Approved: _____ Denied: _____ Effective Date: _____

CDDO Representative Signature:_____
(if denied, reason): _____
_____

When the requested changes are approved, a copy of your request will be distributed to the consumer, parent/guardian and providers. *Request or change of TCM must be submitted on the CHANGE OF TARGETED CASE MANAGEMENT SERVICE PROVIDER form.*

Update 5/05

Note: Along with this request, please complete a WAITING LIST CONSENT FORM located on the reverse side of this form.

SOUTHWEST DEVELOPMENTAL SERVICES, INC.
COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION

WAITING LIST CONSENT FORM

Consumer Name: _____

Address: _____
_____

Parent/Guardian Name: _____

Address: _____
_____

State regulations and our local CDDO policies currently require that we allow all licensed providers in our area access to the names of people on our waiting list **unless** the person requests their name be kept confidential. In order that we may comply with your wishes we ask that you check one of the options with your choice. Failure to complete this form will be considered a **NO** answer.

Please check one of the following options:

_____ Yes, I want my waiting list information released to any licensed provider who makes a request.

_____ No, I do not want my waiting list information released to any licensed provider who makes a request.

You may change your decision at any time by completing a new consent form and submitting the form to SDSI.

Signed _____ **Date** _____

Print Name _____