DEVELOPMENTAL DISABILITIES ADMINISTRATION

Notification Form-Cost Neutral Change

_____ _____ _____
Last Name First Name Middle Name/Initial

_____ _____ _____
Medical Assistance Number Social Security Number Jurisdiction/County

☐ Remains with_____or_____with a change of site address:
(Residential Provider) (Day Provider)
Address_____City/State _____ Zip _____
Anticipated date of change:_____Jurisdiction/County: _____

☐ Anticipated to move from_____ and/or_____to a new waiver provider:
(Residential) (Employment/Day)
Address_____ Address _____
New Provider_____and/or _____
(Residential) (Employment/Day)
New Address _____ New Address _____
(Residential) (Employment/Day)

☐ Anticipated effective date for a change in waiver service_____

From_____to_____(Please write provider/address change above)
Type of Service Type of Service

Examples: Residential Habilitation to CSLA; Supported Employment to Day Habilitation; F/ISS to Supported Living (CSLA)

☐ Has had a change in Coordination of Community Services Agency from_____to
_____, _____
Coordination of Community Services Agency Address

Anticipated effective date_____

Coordination of Community Services indicates reason for change_____

Assurances: Person/guardian initiated ☐ Yes ☐ No, or Agrees ☐ Yes ☐ No Health Safety and Behavioral Needs Met ☐ Yes ☐ No

Site(s) accessible ☐Yes ☐No, and have adequate trained staff to implement individual plan ☐Yes ☐No

Least restrictive alternative ☐Yes ☐ No RC _____ _____
(Print name) (Signature)

CCS agrees with accuracy of information? ☐Yes ☐No Date_____
CCS Comments:

Regional Office confirms: CCS assurances ☐ Yes ☐ No Appropriate licensure ☐Yes ☐No PCIS updated ☐Yes ☐No

Copies to CCS ☐Yes ☐No Copies to Provider ☐Yes ☐No

Reviewed and confirmed by Regional Office ☐ Yes ☐No Signed_____ Date_____
CMRO☐ SMRO☐ ESRO☐ WMRO☐