



Change of Status Form Case Management Services

Contact Information:			
Name (of person completing form):		Agency:	
Office Location/Address:	Phone:	Ext:	
Child's Name:	DOB:	MaineCare:	SSN
Change Child's Demographics: Date of Change:			
<input type="checkbox"/> Legal Name, <input type="checkbox"/> SSN, <input type="checkbox"/> MaineCare#, <input type="checkbox"/> DOB:			
<input type="checkbox"/> Child's Physical Address:		Town	ME Zip
Phone#:			
Change in Disability Category: <input type="checkbox"/> MR/Autism <input type="checkbox"/> MH <input type="checkbox"/> EI/DD Date of Change: _____			
Legal Guardian(s) Name & mailing address:		Guardian(s) Custody	
Phone#:		Married <input type="checkbox"/> yes	
Cell		Sole <input type="checkbox"/> yes	
		Shared <input type="checkbox"/> yes (fill in name/address below)	
		DHHS <input type="checkbox"/> yes	
		Own <input type="checkbox"/> yes	
Shared Custody Name & mailing address:			
Phone#:			
Cell			
Change in Case Management Status			
Case Manager's Name:		Office Location:	Phone: Ext:
Billing start date:		Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> HIFI <input type="checkbox"/>	
		Date of change of level:	
Reason Closed:		Closed to service date:	
Change in child's assigned case manager:		Staff relocation/ new hires/ resigned:	
Date of transfer:		Staff person:	Date:
Name new Case manager (transferred):		Office location:	
Office Location (if Changed):		Phone:	Ext:
		<input type="checkbox"/> New hire date <input type="checkbox"/> Resigned/dismissed	