



**CHANGE OF STATUS**  
MaineCare Section 28,  
Rehabilitative and Community Support Services  
for Children with Cognitive Impairments  
and Functional Limitations (RCS)

|  |  |                                    |
|--|--|------------------------------------|
| <b>Contact Information:</b>  |  |                                    |
| Name (of person completing form): _____  |  | Agency: _____                      |
| Office Location/Address: _____   |  |                                    |
| Phone: _____   | Ext: _____   | Fax: _____                         |
| <b>Child:</b>  | <b>Change in Child's Demographics:</b>                             | <b>New Address:</b>                |
| Name: _____  | <input type="checkbox"/> Legal name:                               | _____                              |
| DOB: _____   | <input type="checkbox"/> SSN: _____                                | _____                              |
| MaineCare #: _____   | <input type="checkbox"/> MaineCare: _____                          | Town: _____                        |
| SSN: _____   | <input type="checkbox"/> DOB: _____                                | State: _____ Zip: _____            |
|  | <input type="checkbox"/> Physical Address                          | Phone: _____                       |
| <b>Please update guardian(s) mailing address</b>   |  |                                    |
| <b>Change in Disability Category:</b>  | <b>Current Category:</b>   | <b>Updated Category:</b>           |
|  | <input type="checkbox"/> MR/Autism                                 | <input type="checkbox"/> MR/Autism |
|  | <input type="checkbox"/> MH  | <input type="checkbox"/> MH        |
|  | <input type="checkbox"/> EI/DD                                     | <input type="checkbox"/> EI/DD     |
| <b>Legal Guardian(s):</b> Name & mailing address   | <b>Guardian(s) Custody</b>   |                                    |
| _____  | Married <input type="checkbox"/> Yes                               |                                    |
| Town: _____  | Sole <input type="checkbox"/> Yes                                  |                                    |
| State: _____ Zip: _____  | Shared <input type="checkbox"/> Yes name/address in Shared Custody |                                    |
| Phone: _____ Cell: _____   | DHHS <input type="checkbox"/> Yes                                  |                                    |
|  | Own <input type="checkbox"/> Yes                                   |                                    |
| <b>Shared Custody:</b> Name & mailing address:   |  |                                    |
| _____  |  |                                    |
| Town: _____  |  |                                    |
| State: _____ Zip: _____  |  |                                    |
| Phone: _____ Cell: _____   |  |                                    |
| <b>Waiting</b>   | <b>Date of Change:</b>   |                                    |
| <input type="checkbox"/> Assigned to   | Provider: _____  |                                    |
| <input type="checkbox"/> Declined offered provider   | Preferred provider name: _____                                     |                                    |
| <input type="checkbox"/> Temporarily Unavailable   | Reason: _____  |                                    |
| <input type="checkbox"/> End review period Return to CE with Comprehensive Assessment and ITP if completed                                   | Reason: _____  |                                    |
| <input type="checkbox"/> Closed CE Referral  | Reason: _____  |                                    |
| <b>In Service:</b>   | <b>Date of Change:</b>   |                                    |
| <input type="checkbox"/> Fully Served  | Reason: _____  |                                    |
| <input type="checkbox"/> Partially Served  | Reason: _____  |                                    |
| <input type="checkbox"/> Service Interrupted   | Reason: _____  |                                    |
| <input type="checkbox"/> Closed/Discharged   |  |                                    |
| <input type="checkbox"/> Discharge Summary   |  |                                    |
| If discharging, does child/family still require this service? <input type="checkbox"/> Yes <input type="checkbox"/> No                       |  |                                    |
| Targeted Case Manager notified <input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> No <input type="checkbox"/> No Case Manager |  |                                    |

**CBHS Website:** <http://www.maine.gov/dhhs/ocfs/cbhs/index.shtml>

Fax Form to:

Region 1 Districts 1 & 2 DHHS/CBHS 161 Marginal Way, Portland, ME 04101 Fax: 822-2358

Region 2 Districts 3, 4 & 5 DHHS/CBHS 200 Main St, Lewiston, Me 04240-3350 Fax: 795-4311 Att: Suzanne Boras

Region 3 Districts 6, 7 & 8 DHHS/CBHS 176 Hogan Rd, Bangor, ME 04401 Fax: 561-5389