

CCW Financial Management Services (FMS) Change Notification Form



**TO BE COMPLETED BY THE CASE MANAGER
(SEE GUIDELINES FOR COMPLETING FORM ON PAGE 2)**

THIS FORM IS NOT FINAL UNTIL IT HAS BEEN SIGNED BY THE CASE MANAGER AND FMS

Participant Name _____ Medicaid ID Number _____
Date of Birth ____/____/____ Plan of Care Dates: FROM (MM/YY) ____/____ TO (MM/YY) ____/____

☐ **Change of Case Manager**

☐ **Change of Case Management Agency**

Prior Case Manager/Case Management Agency: _____

Signature: _____ Date: _____

New Case Manager/Case Management Agency: _____

Signature: _____ Date: _____

☐ **Termination of participant-directed services (\$5125)**

NOTE: If participant-directed services are terminated, a new referral and FMS enrollment packet will be required before services can be reinstated.

Termination effective date: _____

Reason for termination of self-direction: _____

**THIS NOTIFICATION DOES NOT AUTHORIZE PAYMENT FOR SERVICES.
NO PAYMENT FOR SERVICES WILL BE PROCESSED WITHOUT A PRIOR AUTHORIZATION (PA).
PLEASE DO NOT USE WHITE OUT, ERASE, OR MAKE CHANGES TO THIS DOCUMENT.**

Case Manager Printed Name _____

Signature _____ Date _____

Case Management Agency _____

Address _____

Fax # _____ Phone # _____

Fax co

TO BE COMPLETED BY THE FMS

PLEASE FAX OR MAIL A SIGNED COPY TO THE CASE MANAGER LISTED ABOVE WITHIN **5 BUSINESS DAYS** FROM RECEIPT

☐ I acknowledge receipt of notification of changes that will impact participant-directed services for:

Participant Name _____

FMS Signature _____ Date _____

Case Manager Guidelines for Completing FMS Change Form Notification:

1. This form must be:
 - a. Completed by the case manager
 - b. Faxed or emailed to the FMS for signature
(fax and email information are found on page 1)
 - c. Returned to the case manager for upload into the EMWS record
2. This form is to be completed **prior** to:
 - a. Any change in case manager or Case Management Agency
 - b. Any termination of a service
3. Complete the form in its entirety based on the information below

Participant Name, Medicaid ID #, Date of Birth, Plan of Care Dates:	Enter information as it appears on the participant screen in the EMWS. Enter dates indicated for the service plan begin and end dates.
Change of Case Manager/Case Management Agency:	Form must include the signature of the incoming and outgoing case manager.
Termination of Participant-Direction:	Termination of participant-direction services will result in the closure of the FMS employer file for that individual. If the participant decides to re-enroll in participant-direction after services have been terminated, a new enrollment packet will required before services will be authorized.
Case Manager Signature and Contact Information:	Signature verifies that the requested changes and dates are correct based on the service plan and subsequent modifications. If the form is submitted for a change in case manager, the incoming case manager must verify, sign, and submit.