



Change of Status Form Day Habilitation

Contact Information:

Name (of person completing form):

Agency:

Office Location/Address:

Phone:

Ext:

Child's Name:

Change in Child's Demographics:

DOB:

MaineCare:

SSN:

Legal name

SSN

MaineCare

DOB:

Child's Physical Address:

Phone:

Town:

ME Zip:

Please update guardian(s) mailing address

Change in Disability Category:

MR/Autism

MH

EI/DD

Legal Guardian(s) Name & mailing address:

Phone#:

Cell

Guardian(s) Custody

Married yes

Sole yes

Shared yes name/address in Shared Custody

DHHS yes

Own yes

Shared Custody Name & mailing address:

Phone#:

Cell

Waiting

Date of Change:

Matched with Provider:

Refusing offered provider Preferred provider name:

Temporarily Unavailable Reason:

End review period return to CE Reason:

Closed CE Referral Reason:

In Service

Date of Change:

Fully Served

Partially Served

Service Interrupted Reason:

Closed/Discharged Reason:

If discharging, does child/family still require this service? Yes or No.

Has Targeted Case Manager been notified? Yes or No