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CFSS Technical Change Request Form

CFSS and other CFSS related service providers complete and submit this form to request technical changes to service authorizations.

The services requested must already be approved in a current CFSS Individual Service Delivery Plan DHS 6893P in order to use this form. You must request a new CFSS individual service delivery plan if you are requesting a new service not already approved within the current service delivery plan.

MEMBER'S INFORMATION (Required)	
Last Name, First Name, Middle	
8 Digit Member ID *(also known as PMI Number)*	
Date of Birth	
CFSS Model *(Choose one):*	☐ Agency Model ☐ Budget Model ☐ Not Yet Determined
Dates of the approved service delivery plan affected by your request: **Start Date:** **End Date:**	

YOUR AGENCY INFORMATION (Required)	
Name of Your Agency	
Your Name and Title	
Your Phone Number	
Address of Your Agency	

CHANGE REQUESTED (Required)
(Select all that apply – CTRL + Click each ink and complete requested information)
☐ Provider change/update
☐ Change/update person's information
☐ Health plan enrollment (person previously had fee-for-service authorization)
☐ Other (increases to consultation services or worker training and development, updates to participant representative or another request)

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PROVIDER CHANGE/UPDATE
(Select all that apply – CTRL + Click each link and complete requested information)
☐ New provider (requires person or participant's representative signature)
☐ Discontinuing provider
☐ Partial release of CFSS personal care services due to multiple providers (agency model only)

NEW PROVIDER	
Name of the person who signed Release	
Date of Signature	
Relationship to Member (if Member is their own responsible party, enter "Self")	
☐ As the NEW provider of a currently approved service, I have received/maintained the signature of the person or participant's representative requesting this change.	
Select the currently approved service(s) this agency will provide to the member.	
Please check all that apply:	**Enter First Date of Service:**
☐ **Personal Care Services and Worker Training & Development**	
☐ **Consultation Services**	
☐ **FMS Fee**	
☐ **Failed Background Study**	
☐ **Goods and Services**	
☐ **Personal Emergency Response System-PERS**	
Additional Information (You may attach additional document if needed.)	

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DISCONTINUING PROVIDER		
Select the service(s) this agency will discontinue to the member.		
☐ **Personal Care Services and Worker Training & Development**	**Last Date of Service:**	**Total Dollars or Units Used:** $ Units
☐ **Consultation Services**	**Last Date of Service:**	**Total Dollars or Units Used:** $ Units
☐ **FMS Fee**	**Last Date of Service:**	**Total Dollars or Units Used:** $ Units
☐ **Failed Background Study**	**Last Date of Service:**	**Total Dollars or Units Used:** $ Units
☐ **Goods and Services**	**Last Date of Service:**	**Total Dollars or Units Used:** $ Units
☐ **Personal Emergency Response System-PERS**	**Last Date of Service:**	**Total Dollars or Units Used:** $ Units
Additional Information (You may attach additional document if needed.)		

PARTIAL RELEASE OF CFSS PERSONAL CARE SERVICES Due to Adding Additional CFSS Providers (Agency Model Only)	
Total units your agency will release to other CFSS provider agency(ies) also serving the member.	

CHANGE/UPDATE FOR PERSON'S INFORMATION Select all that apply:
☐ Person information change
☐ Eligibility update
☐ Living arrangement update
Explain:

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HEALTH PLAN ENROLLMENT (person previously had fee-for-service authorization)			
Select the service(s) you provide for the member:		**Start Date:**	**End Date:**
☐	**Personal Care Services and Worker Training & Development**		
☐	**Consultation Services**		
☐	**FMS Fee**		
☐	**Failed Background Study**		
☐	**Goods and Services**		
☐	**Personal Emergency Response System-PERS**		

OTHER	
Select/Complete all that apply:	
Report changes in participant's representative.	**Participant representative's name:** **Relationship to the person:**
Request an increase in consultation service authorization.	**Additional units requested:** **Explanation for the increase:**
Request an increase for worker training and development.	**Additional amount requested:** **Explanation for the increase:**