



Consumer Information Update Form

Consumer Name:

Consumer ID#:

	First	Last	
Type of Update	Effective Date	Provide Only the Information to be Updated	
<input type="checkbox"/> Consumer			<input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> County <input type="checkbox"/> Phone <input type="checkbox"/> Email Address
<input type="checkbox"/> Current Representative <input type="checkbox"/> New Representative			<input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Phone <input type="checkbox"/> Email Address If New Representative: <input type="checkbox"/> Representative fully trained in CDC+. <input type="checkbox"/> Representative Agreement executed.
<input type="checkbox"/> Legal Status <small>(If minor, enter name, address, and ph. number of parents OR Legal Guardian. If adult has Legal Representative, enter name, address, and ph. number of Legal Representative.)</small>			<input type="checkbox"/> Minor: Parental Guardian <input type="checkbox"/> Minor: Other Legal Guardian* <input type="checkbox"/> Competent Adult: no legal guardian <input type="checkbox"/> Adult: Legal Representative* <small>has authority over medical decisions and/or government benefits.</small> <input type="checkbox"/> *Consultant has filed legal document in consumer's primary file.
<input type="checkbox"/> New Consultant <small>(Use Consultant Registration Update Form to record changes in name, add, ph, email, agency, etc.)</small>			Name: _____ Medicaid <u>Treating</u> Provider # for CDC+: _____ <input type="checkbox"/> Consumer/Consultant Agreement executed <input type="checkbox"/> Consultant name changed in ABC <input type="checkbox"/> CDC+ MOA executed
<input type="checkbox"/> Stop Budget (Disenrollment) <input type="checkbox"/> Reinstate budget <small>(Consumer off CDC+ for 90 days or less)</small> NOTE: Consumers who have been off CDC+ for more than 90 days must let APD know if they are interested in returning to CDC+.			Reason for Disenrollment: <input type="checkbox"/> Death of consumer (11) DATE: _____ <input type="checkbox"/> Ineligible for Medicaid (12) <input type="checkbox"/> Residential Placement (21) DATE: _____ <input type="checkbox"/> Improved functioning/health status (22) <input type="checkbox"/> Increased informal support (23) <input type="checkbox"/> Representative not available (32) <input type="checkbox"/> Mismanagement of budget (33) <input type="checkbox"/> CDC+ staff/consultant initiated (34) <input type="checkbox"/> Inability to employ/manage workers (41) <input type="checkbox"/> Consumer/representative request (42) <input type="checkbox"/> Temporary hospitalization (90) <input type="checkbox"/> Other (99) _____

Consultant Signature

Date

Print Consultant and Agency Name

Area Liaison Signature

Date

Print Name and APD Area Office #