Wyandotte County Developmental Disabilities Organization

Notice of Information Change

Consumer Name: _____ **Effective Date:** _____

Notice Completed by: _____ **Agency:** _____

Please check the box for the appropriate section in which changes are being made. It is **not necessary** to fill out any sections in which no changes are being made. Attach any pertinent documents or forms as needed. Return the completed form to the WCDDO 701 N 7th, Room 346, Kansas City, KS 66101 or FAX 913-573-5511.

ACTION REQUIRED:

- Consumer Contact Information
- Medicaid Number
- Intellectual/Hearing/Vision
- Guardian Information
- Change in Case Management
- Diagnoses (DSM-IV)
- Change in Services Section
- Other ______________________

1) CONSUMER CONTACT INFORMATION

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

County of Residence: _____

County of Origin: _____

Medicaid # Change:_____

2) IQ / HEARING / VISION:

IQ Scores: _____

Hearing: _____

Vision: _____

3) GUARDIAN CONTACT INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

4) CHANGE OF CASE MANAGEMENT WITHIN PROVIDER:

A transition meeting is not necessary when an individual is changing Case Managers within the same agency.

Previous Case Manager: _____

New Case Manager: _____

New CM Contact _____

5) PSYCHIATRIC DIAGNOSIS (DSM-IV):

1. _____ _____
2. _____ _____

Updated 6/29/2015

Choose the requested services then type provider name and date requested.

	Name of Service	Provider Name	Date Requested
☐	Targeted Case Management		
☐	Residential		
☐	Day		
☐	In-Home Supports		
☐	Direct Financial Supports		

Choose the entered service then type in the providers name, date entered and funding source.

	Name of Service	Provider Name	Date Entered	Funding
☐	Targeted Case Management			
☐	Residential			
☐	Day			
☐	In-Home Supports			
☐	Direct Financial Supports			

Funding Source Codes

1 HCBS
2 State Funds Only
3 Discretionary Funds
4 County Mill Levy
5 Certified Match
6 Vocational Rehabilitation
7 Other

Choose the closing services then type in provider name and closing date.

	Name of Service	Provider Name	Date closed
☐	Targeted Case Management		
☐	Residential		
☐	Day		
☐	In-Home Supports		
☐	Direct Financial Supports		

Check Reason Closed

☐	Deceased
☐	Wrong Social Security #
☐	Moved (without transfer)
☐	Self-Removal
☐	Transferred
☐	Terminated
☐	Other