agency for persons with disabilities
State of Florida

Participant Information Update Form

CDC+ Consumer-Directed Care Plus

Participant Name: _____ **Participant ID#:** _____
First Last

What to Update		Provide Only the Information to be Updated
☐ **Participant**	**Effective Date**	☐ Name Change* or Correction _____ ☐ Address _____ ☐ City, State _____ ☐ County _____ ☐ Zip _____ ☐ Phone (indicate type) _____ ☐ Email Address _____ * A legal name change requires supporting legal documentation.
☐ **Current Representative** ☐ **No Representative** ☐ **New Representative** __ **Parent** __ **Spouse** __ **Other Rel** __ **Friend**	**Effective Date**	☐ Name _____ ☐ Address _____ ☐ Phone _____ ☐ Email Address _____ **If changing from Rep to <u>No</u> Rep, ☐ Participant has been fully trained in CDC+.** **If <u>New</u> Representative:** ☐ Representative fully trained in CDC+. ☐ Representative Agreement executed.
☐ **Legal Status** (If minor, <u>enter</u> name, address, and phone number of parents **OR** Legal Guardian. If adult has Legal Representative, <u>enter</u> name, address, and phone number of Legal Representative. Use all lines)	**Effective Date**	☐ Minor: **Parental Guardian** _____ ☐ Minor: **Other Legal Guardian*** _____ ☐ Competent Adult: no legal guardian _____ ☐ Adult: **Legal Representative*** _____ has authority over medical decisions _____ and/or government benefits. _____ ☐ *Consultant has filed legal document in consumer's primary file.
☐ **New Consultant** (Use **Consultant Registration Update Form** to update consultant name, address, phone, email, agency affiliation, etc.)	**Effective Date**	Name: _____ Medicaid <u>Treating</u> Provider # for CDC+: _____ ☐ Participant-Consultant Agreement has been executed. ☐ ABC has been updated. **Copy of ACLM3 Screen is attached.**
☐ **<u>Stop</u> Budget (Dis-enrollment)** ☐ **<u>Reinstate</u> budget** **NOTE:** In order to be reinstated, consumer's date of <u>dis-enrollment</u> cannot be greater than 12 months prior to reinstatement date AND upon dis-enrollment, participant must have indicated a desire to return to the program.	**Stop Date (LAST OF <u>MONTH</u>)** **Reinstate Date (FIRST OF <u>MONTH</u>)**	**Indicate Reason for Dis-enrollment (required) from either area A or B, below:** **A. Mandatory Dis-enrollment as a result of:** ☐ Death of participant **DATE:** _____ ☐ Residential placement **DATE:** _____ ☐ Participant Moved out of State **DATE:** _____ ☐ Hospitalization > 30 days **DATE:** _____ ☐ Loss of Medicaid eligibility > 90 days **Last Day Eligible:** _____ ☐ Loss of Waiver eligibility **Last Day Eligible:** _____ **B. If either of the following, indicate why:** ☐ **Participant/representative request <u>OR</u>** ☐ **APD staff/consultant initiated** ☐ Representative not available / ☐ Representative not available ☐ Inability to manage program / ☐ Inability to manage program ☐ Inability to manage budget / ☐ Inability to manage budget ☐ Consumer health/safety at risk / ☐ Consumer health/safety at risk ☐ **Copy of Participant Account Close-Out Form is attached (required)**

_____
Consultant Signature **Date** **Print Consultant <u>and</u> Agency Name**

_____
Area Liaison Signature **Date** **Print Name <u>and</u> APD Area Office #**