SEDGWICK COUNTY DEVELOPMENTAL DISABILITY
CONSUMER INFORMATION CHANGES

Name: _____ SSN: _____ Date: _____

Individual requesting change: _____ Relationship: _____

1. Name change: _____ Reason for change: _____
(There must be documentation to support a name change.)

2. Address change: _____ City: _____ State: _____ Zip: _____

3. Home phone: _____ Cell phone: _____

4. County of residence: _____ Home county: _____

5. Medicaid ID: _____ Medicare: _____

6. Gender: _____

7. Race _____ Ethnicity _____

8. Residential Status (choose the option that best describes the living situation)

_____

If living with non-relatives who are not MRDD please list relationships or if you selected other please describe.

_____

9. Day Program (list up to 3 day programs)

_____

_____

_____

If Other, please explain: _____

10. Indicate all identified disabilities: (There must be documentation to support a change.)

1. I/DD ○ Yes ◉ No
2. Autism ○ Yes ○ No
3. Cerebral Palsy ○ Yes ○ No
4. Epilepsy/Seizure Disorder ○ Yes ◉ No
5. Other (cognitive disabilities only, please describe): _____

11. Primary Disability (list 1-5 from above): _____

12. Special Population (may choose up to 3 special populations):

_____

_____

_____

If in DCF custody, list child placing agency: _____

13. Psychiatric Diagnosis (There must be documentation to support a change.)

If the individual has no psychiatric diagnosis, leave this field blank. Do not enter a DSM-IV code for any of the identified disabilities marked in #11 above. You must use BASIS DSM IV codes.

1. 2. 3.

14. Intellectual Assessment (There must be documentation to support a change.)

Enter the one category which best indicates the individual's level of intellectual functioning based on the most recent psychological assessment available. If mental retardation was entered as the primary disability in number 11, you may not enter #1.

15. Hearing (There must be documentation to support a change.)

16. Vision (There must be documentation to support a change.)

Mark the category which best describes the person's vision with the use of glasses or contact lenses if used. Please note that legally blind may not necessarily be #5, `Total blindness'. A person could be legally blind without being totally blind. For a person who is fully sighted in one eye only, mark #2, `Moderate impairment'.

17. Family/Relationships (The legal court document must be submitted to add or change a guardian.)

Please list any additions or changes in foster care family, foster care case manager/social worker, MCO care coordinator, family, relationships, guardian, out of county TCM, etc. Please provide any additional information on a separate sheet.

Name: Relationship:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Other Phone: Email Address:

Name: Relationship:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Other Phone: Email Address:

Name: Relationship:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Other Phone: Email Address:

18. Targeted Case Manager: TCM Agency:

TCM Phone Number: TCM Email:

19. Primary Language: Secondary Language:

Is an interpreter needed?

20. Marital Status:

21. Veteran Information

Is the individual a veteran?

Is the individual's spouse a veteran?

Does the individual receive veteran's benefits?

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