DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

CDC+ Consumer-Directed Care Plus

CHANGE FORM

Consumer Name:	Consumer ID:

☐ Elders ☐ Adult Services ☐ Brain/Spinal Cord Injury

☐ **Change of Address**

☐ Consumer ☐ Representative ☐ Consultant

Phone( ) Email:

☐ **Change Consultant**

Name:
Address:
Phone( ) Email:

☐ **Change Monthly Allocation** | New Amount: Effective Date: / /

☐ **Stop Monthly Allocation** Stop Date Effective: _____/_____/_____

☐ Death of Consumer-Date: _____
☐ LTC Facility Admission
☐ Consumer/representative request
☐ Improved functioning/health status
☐ Representative not available
☐ Ineligible for Medicaid/Medicaid Waiver
☐ Mismanagement of budget
☐ Inability to employ/manage workers
☐ CDC+ staff or Consultant initiated
☐ Increased Informal Support
☐ Temporary Hospitalization
☐ Other

_____ _____

Consultant Signature **Date**

_____ _____

Authorized Signature **Date**