Macomb County Mental Health Services

Change Form - Program & Staff Assignments

Consumer Information:		***Request Date*** (Date sent to the Supervisor):	
Name:		Case #:	
Phone Number:		Insurance Type:	

Program Assignment (Choose reason for request)						**Effective Date of Change**	
Make Primary:		Program Assignment (add or end):		Staff Assignment (add or end):		Discharge from ALL services:	
Comments:							

Change Primary Assignment:	***Referral from:***		***Referral to:***	
What specific services are being requested:				

Clinical Documentation (date of last completed signed document)					
Periodic Review:		PCP:		Most Recent Assessment:	
Fee Agreement / Ins. Auth:		Acknowledgment & Consent:		Dx Code:	

Service Authorizations (all program assignments will need service authorization)							
Provider name:				Provider name:			
Effect Date:		Exp Date:		Effect Date:		Exp Date:	
Provider name:				Provider name:			
Effect Date:		Exp Date:		Effect Date:		Exp Date:	

Staff Assignment (completed by supervisor)				Psychiatrist		Peer Specialist	
Primary Staff:		RN		Therapist		Group Therapist	

Comments:

If services are denied, indicate reason:	Note: If declined, talk to referring agency before sending Due process to consumer

Receiving agency to forward completed form to all of the above assigned clinicians, T III's & Account Clerks at each program