

**North Carolina
Home Care Independence Program**

**Change Order Notice for
Financial Management Services**

Date: _____

Participant's Name; _____

Date of Birth: _____

Address: _____

City/State/Zip: _____

Phone: (____) _____

Change Order Information: *mark all that apply*

- a. The following **Personal Assistant** has been **terminated** from employment effective _____
Name of Personal Assistant _____
- b. The **Participant** is **temporarily suspended** from Consumer Directed Services (CDS) effective _____
- c. **Resume FMS** for **Participant** effective _____
- d. The **Participant** has been **terminated** from CDS effective _____
- e. There is a **change** in the **Care Advisor**: Name _____
Tele# _____ E-mail _____

f. There is a change in the following:

a. **PAYROLL SERVICES (CODE 501/Personal Assistant):**

TOTAL HOURS AUTHORIZED: _____ PER WEEK

MONTHLY BUDGET FOR PAYROLL (unit rate) _____ X hours _____ X 4.333) =
\$ _____

b. **VENDOR PAYMENTS FOR COMMUNITY GOODS/SERVICES:**

PERSONAL CARE/ENVIRONMENTAL/NUTRITIONAL SERVICES (CODE 504): \$ _____

EMERGENCY RESPONSE EQUIPMENT (CODE 506): \$ _____

MEDICAL ADAPTIVE EQUIPMENT (CODE 507): \$ _____

c. **Effective date of change for hours:** _____ **and Effective date of change for vendor payments;** _____

e. Other (specify) _____

Submitted by: _____, Care Advisor

Phone: (____) _____ Agency _____