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 _____