HCBS MEMBER COMMUNICATION FORM

A communication tool between Providers and Care Coordination to report key member updates, needs, changes and issues. Send within 3 business days of reported event.

Date: Click here to enter text	**To (Entity Name):** Click here to enter text
From (Entity Name): Click here to enter text	**Contact Info (email/phone):** Click here to enter text

Member Name: Click here to enter text	**RIN:** Click here to enter text
	DOB: Click here to enter text
Address: Click here to enter text	☐ **Mark if New Address:**
Phone Number: Click here to enter text	☐ **Mark if New Phone Number:**

Reason for the Communication:

☐ Initiate Services ☐ Notification to Start Services ☐ Confirm Start Date ☐ Change in Services

☐ Service Hold ☐ Resume Service ☐ End Service ☐ Member Changes/Issues

☐ CountyCare Disenrollment ☐ Other Click here to enter text

Attachment: ☐ Yes ☐ No

Explanation (skip if N/A):

Click here to enter text

Applicable Dates (skip if N/A): Click here to enter text	
Start or Effective Date: Click here to enter text	**Resume Date:** Click here to enter text
Hold Date: Click here to enter text	**End Date:** Click here to enter text

Service(s) Impacted:

☐ Homemaker Services ☐ Adult Day Service ☐ Home Delivered Meals ☐ Emergency Home Response

☐ Other: Click here to enter text

Sender Name: Click here to enter text **e-Signature:** _____ **Date:** Click here to ente

Recipient Response
(respond w/in 3 business days of receipt, if applicable): Click here to enter text

Responder Name: Click here to enter text **e-Signature:** _____ **Date:** Click here to ente

Complete and send to the member's Care Coordinator or countycarewaivers@cookcountyhhs.org