Clinically Responsible Service Provider (CRSP) Change Form

(**This form is for CRSP change only, not to be used for Program/Disability Designation Change**)

Instructions: To change CRSP Provider:
(1) Complete the form. (**2**) Have the member or legal representative sign to ensure choice. (**3)** In case of disagreement with the proposed change (by the member, legal representative, current or new CRSP) contact DWIHN Customer Service: 313-833-3232.
(**4**) Approved changes will be effective within three business days of date received by the Access Center.

STEP 1: Fill out the boxes below. If you need help, call a **DWIHN Access Center Representative at 1-800-241-4949 or (TDD) 1-866-870-2599 for the Hearing Impaired.**

First Name: **(Please Print)** Middle Initial: Last Name:	
Street: City: Zip Code:	
Date of Birth:	Sex: Male ____ Female ____ Other: ___________
Home Phone Number: ( )	Cellular Phone Number: ( )
Work Phone Number: ( )	E-mail:
Social Security Number:	
Do you have Medicaid? Yes ____ No ____ If yes, provide your Medicaid ID#: ___________________	
Your First Language is: ___English _____Arabic ___Chinese ___Italian ____Polish ___Spanish ____Other: Specify ________________________	

STEP 2: Complete Information below by selecting one CRSP only and document reason for change. Please consult your Provider Directory for the different locations and addresses. You can receive a Provider Directory from DWIHN Customer Service, on the Website at www.dwihn.org or at a Provider location.
Populations Served: I/DD=Intellectual/Developmental Disability, SMI=Severe Mental Illness, SED=Serious Emotional Disabilities,

PROPOSED CRSP	
Population Served: Adults, Children/Adolescents/Youth with I/DD, SMI & SED	
☐ All Well Being Services (AWBS)	☐ Neighborhood Services Organization (NSO) – ***No SED Children***
☐ Arab Community Center for Economic and Social Services (ACCESS)	☐ Psygenics
☐ Community Network Services (CNS) Healthcare	☐ Team Wellness Center
☐ Development Centers	☐ The Guidance Center
☐ Hegira Health, Inc.	
Population Served: Adults, Children/Adolescents/Youth with SMI & SED	
☐ American Indian Services	☐ Community Network Services (CNS) Healthcare
☐ Arab American and Chaldean Council (ACC)	☐ Lincoln Behavioral Services
☐ Black Family Development, Inc.	☐ Ruth Ellis Center
☐ Community Care Services	☐ Southwest Counseling Solutions
Population Served: Adults, Children/Adolescents/Youth with I/DD	
☐ Community Living Services	☐ Macomb-Oakland Regional Center, Inc. (MORC)
☐ Goodwill Industries of Greater Detroit	☐ Spectrum Community Services
	☐ Wayne Center
Population Served: Adults Only with I/DD	
☐ JVS Human Services	☐ Services to Enhance Potential (STEP)
Population Served: Adults Only with SMI	
☐ Central City Integrated Health (CCIH)	
Population Served: Children/Adolescents/Youth with I/DD & SED	
☐ Starfish Family Services, Inc.	☐ The Children's Center
Population Served: Children/Adolescents/Youth with SED	
☐ Assured Family Services	

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Please list reason for proposed CRSP reassignment (check that which applies)**:**

- ❑ Change in disability designation
- ❑ Current CRSP does not have capacity for services needed
- ❑ Individual/Legal Representative requested – Reason: (i.e., moved, dissatisfied with staff/agency/services, etc)
  ____
- ❑ Other: ____

STEP 3: Member Signature. My signature below confirms I have requested to change my CRSP as indicated above. My options have been fully explained to me as well as my right to dispute and appeal as needed.

Signature:	Date:
Print Name:	
Signature of the person helping you fill out the form (as applicable):	

STEP 4: Fill out the box below if you are the legal guardian or an appointed power of attorney for the member. If you need help, call **a DWIHN Access Center Representative at:1-800-241-4949 or (TDD) 1-866-870-2599 for the Hearing Impaired.**

Signature:	Date:
Print Name:	
Address:	
Phone Number: ( )	E-mail:
Relationship:____Parent:____Family Member____Spouse____Other _____Legal Representative	

STEP 5: Mail your application back to the address below (currently no walk-ins are being accepted).
This form can be mailed, emailed or faxed to the Access Center

DWIHN Access Center
707 Milwaukee
Detroit, MI 48202
Email: crspprovider@dwihn.org
Fax: 877-909-3950

You will receive a confirmation letter of your enrollment in the mail within 14 days of the effective date.

******This section to be completed by the Access Center only***

The CRSP change has been discussed with the individual receiving services and will be effective on:__________________

____ ______________________
Access Center Authorized Representative Date