



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

- | | |
|--|--|
| <input type="checkbox"/> All Well Being Services (AWBS) | <input type="checkbox"/> Neighborhood Services Organization (NSO) – No SED Children |
| <input type="checkbox"/> Arab Community Center for Economic and Social Services (ACCESS) | <input type="checkbox"/> Psygenics |
| <input type="checkbox"/> Community Network Services (CNS) Healthcare | <input type="checkbox"/> Team Wellness Center |
| <input type="checkbox"/> Development Centers | <input type="checkbox"/> The Guidance Center |
| <input type="checkbox"/> Hegira Health, Inc. | |

Population Served: Adults, Children/Adolescents/Youth with SMI & SED

- | | |
|---|--|
| <input type="checkbox"/> American Indian Services | <input type="checkbox"/> Community Network Services (CNS) Healthcare |
| <input type="checkbox"/> Arab American and Chaldean Council (ACC) | <input type="checkbox"/> Lincoln Behavioral Services |
| <input type="checkbox"/> Black Family Development, Inc. | <input type="checkbox"/> Ruth Ellis Center |
| <input type="checkbox"/> Community Care Services | <input type="checkbox"/> Southwest Counseling Solutions |

Population Served: Adults, Children/Adolescents/Youth with I/DD

- | | |
|---|--|
| <input type="checkbox"/> Community Living Services | <input type="checkbox"/> Macomb-Oakland Regional Center, Inc. (MORC) |
| <input type="checkbox"/> Goodwill Industries of Greater Detroit | <input type="checkbox"/> Spectrum Community Services |
| | <input type="checkbox"/> Wayne Center |

Population Served: Adults Only with I/DD

- | | |
|---|---|
| <input type="checkbox"/> JVS Human Services | <input type="checkbox"/> Services to Enhance Potential (STEP) |
|---|---|

Population Served: Adults Only with SMI

- | | |
|--|---|
| <input type="checkbox"/> Central City Integrated Health (CCIH) | <input type="checkbox"/> Elmhurst Home Inc. |
|--|---|

Population Served: Children/Adolescents/Youth with I/DD & SED

- | | |
|---|--|
| <input type="checkbox"/> Starfish Family Services, Inc. | <input type="checkbox"/> The Children's Center |
|---|--|

Population Served: Children/Adolescents/Youth with SED

- | |
|--|
| <input type="checkbox"/> 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