

CASE MANAGEMENT

**CHOOSING BETWEEN the KANSAS CITY REGIONAL OFFICE
and
DEVELOPMENTAL DISABILITY SERVICES OF JACKSON COUNTY – eitas**

(Please Print)

Name _____ DOB ____/____/____

Street Address _____ Apt. No. _____

City _____ State _____ Zip _____

Telephone Number. _____ Other Number . _____

Current Service Provider(s) _____

DMH ID Number _____ Medicaid Number _____

Medicaid Status (*Circle Correct Response*) Active Inactive

Current Kansas City Regional Office Service Coordinator: _____

- I would like to receive case management (Support Coordination) from the Developmental Disability Services of Jackson County – eitas. My signature below authorizes exchange of information between the Kansas City Regional Office and the Developmental Disability Services of Jackson County – eitas

- I would like to receive or continue to receive, case management from the Kansas City Regional Office

Signature: _____

If Guardian, please print name _____

Address: _____

City/State/Zip: _____ Phone: _____

Please fax or mail form to:

Developmental Disability Services of Jackson County – eitas
8511 Hillcrest, Suite 300
Kansas City, MO 64138

or Fax to: (816) 363-1755

OFFICE USE ONLY: Date Received at eitas: _____
Date KCRO Notified/Form Faxed to: _____

Please Note: Until notified by eitas of the transition, Service Coordination will continue through the Kansas City Regional Office