Illinois Department of Human Services – Division of Developmental Disabilities – Bureau of Quality Management
Change of Individual Status on Review

Name of Agency: Date of Review:

Individual's Name: Sample #:

Type of review: ☐ CILA ☐ CDS ☐ SDA ☐ CRW

| Reason for Change of Status | Date of Change |
|---|---|
| ☐ Transfer to different Agency/Provider | |
| ☐ Death | |
| ☐ Transfer out of Services | |
| ☐ Discontinue SDA | |
| Additional Information Needed | |
| ☐ Alternate Needed | Contact supervisor for alternate individual |
| ☐ Address Change of Residence | New Address: |
| ☐ Other | Description: |
| ☐ Name of new Agency/Provider | |
| ☐ Address of new Agency/Provider | |
| Type of Services being Provided at new Agency/Provider | ☐ CILA ☐ CDS ☐ SDA ☐ CRW ☐ ICFDD ☐ SODC |
| | Comments/Notes: |
| | Reviewer: |

For Supervisor use:

| Follow up Assigned | Reviewer Assigned | Date Assigned | Notes |
|---|---|---|---|
| ☐ Desk Audit | | | |
| ☐ Record Assigned to Correct Agency | | | |
| ☐ Alternate Assigned and Scheduled | | | |
| ☐ Other | | | |
| | | | |
| | | | |
| | | | Supervisor:<br>Date: |