



Adult Mental Health Division
 Representative Payee Program
Change of Event Report - Demographics

FAX TO: (808) _____

Consumer Name: _____

Case Manager: _____

Check appropriate boxes and complete all information for each box checked.

Change of RESIDENCE Date Moved: _____
 New Address: _____
 RENTAL AGREEMENT ATTACHED

Change in LEGAL ENCUMBRANCES Status
 Consumer ADMITTED Date: _____ Consumer DISCHARGED Date: _____
 Jail Prison Penal Institution
 Name of Institution: _____ If DISCHARGED, attach discharge paper (1pg)

WARRANT/BENCH WARRANT Date initiated: _____

Change in MEDICAL/PSYCHIATRIC INSTITUTION Status
 Consumer ADMITTED Date: _____ Consumer DISCHARGED Date: _____
 Psychiatric Institution Psychiatric Institution
 Name of Institution: _____ If DISCHARGED, attach discharge paper (1pg)

Change in MARITAL Status Date: _____
 Married Divorced Separated
 Other ATTACH CERTIFIED ORIGINAL COPY

Change in SCHOOL Status
 Start Date: _____ Stop Date: _____

Report DEATH of: Date of Death: _____
 Consumer Spouse Child Parent
 Report BIRTH of child Date of Birth: _____
 ATTACH CERTIFIED ORIGINAL COPY

Change in CITIZENSHIP/IMMIGRATION Status
 Outside the US for more than 30 days
 Other: _____ ATTACH ORIGINAL

Information needed for Representative Payee Program:
 Change in COMMUNITY BASED CASE MANAGEMENT or AGENCY status
 Case Management Agency to Case Management Agency Date: _____
 From: _____ To: _____
 Case Manager to Case Manager Date: _____
 From: _____ To: _____
 Discharged from CBCM Date Auth Sent to UM: _____