

***CHANGE OF STAFF FORM***

***Adding/Deleting Staff to/from current New Jersey Medicaid Identification Number***

*Please check one :*

* Add Staff
* Delete Staff

**1. Provider/Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Existing Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Requested Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5. Staff Members Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7.SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**8. If Bilingual, specify the Language(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**9. Service Type: IIC \_\_\_\_\_ BA \_\_\_\_\_ IIH Clinical/Therapeutic \_\_\_\_\_\_ IIH Behavioral \_\_\_\_\_\_**

 **ISS(Tech 1)\_\_\_\_\_ (Tech 2)\_\_\_\_\_ (Tech 3)\_\_\_\_\_\_**

**10. NJ Clinical License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**11. License/Certification Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 12.Certificate # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name of New Staff Signature of New Staff Date**

If Adding Staff:

ATTACH COPY OF CURRENT LICENSE(S) AND BOARD CERTIFICATION(S) IF APPLICABLE

ATTACH COPY OF CURRENT RESUMES FOR ALL STAFF BEING ADDED

PROVIDER AGREES: To comply with all program participation requirements as agreed in accordance with your original Provider Agreement with the New Jersey Division of Medical Assistance and Health Services (DMAHS) (reference FD-62). To comply with the Children’s System of Care (CSOC) policies, procedures, and regulations.

THE CHILDREN’S SYSTEM OF CARE, PROVIDER/AGENCY OR DMAHS MAY, ON 60 DAYS WRITTEN NOTICE TO THE OTHER PARTY, TERMINATE THIS AGREEMENT.

**Provider Agency Representative Information:**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

 **Name of Provider Agency Signature of Provider Representative Email/Phone Date**

Department of Children and Families

Division of Children’s System of Care

PO Box 717

Trenton, NJ 08625