Case Management
Services, Inc. (CMS, Inc.)

7600 W 75th St, OP, KS 66212

FINANCIAL AGREEMENT FOR SERVICES

Name: ______________________________ SS#: ______________

Date of Birth: ______________ Home#: ______________ Work#: ______________

Address: ______________________________ State: ________ Zip: ________

I ______________________________ **hereby request that CMS, Inc. serve as** ______________

my Targeted Case Manager effective on ______/______/_____ Until the date notified by Johnson County Community Developmental Disability Organization (CDDO) that her services are no longer requested and at that time services will be discontinued with CMS, Inc. by the process in place with the CDDO.

Targeted Case Management services are paid through Medicaid funding and the individual served and their family will not be charged for these services or responsible for the billing of these services. Kansas Medicaid will require that I bill primary insurance, as Medicaid is payer of last resort.

Date: ____ / ____ / ______ Signature of Person Served: ______________________________

Date: ____ / ____ / ______ Signature of Authorized Representative: ______________________________

Date: ____ / ____ / ______ Targeted Case Manager: ______________________________

Please complete the following section if signed by Parent/Guardian or Authorized Representative

Printed Name of Parent/Guardian or Authorized Representative: ______________________________

Address: ____________________ City: ______________ State: ________ Zip: ________

Phone: ____________________ Relation to Person Served: ______________________________