Beneficiary Name: _____ MID#:_____

FOR NON-MEDICAL CHANGE OF STATUS OR CHANGE OF PROVIDER REQUESTS, COMPLETE THIS PAGE ONLY.

Step 1

Please select one: ☐ Change of Status: Non-Medical ☐ Change of PCS Provider **Date of Request:**___/___/___

Step 2

Beneficiary's Name: First:_____ **MI**:___ **Last**:_____ **DOB:** ____/____/_____

Medicaid ID#: _____ Gender: ☐ M ☐ F Language: ☐ English ☐ Spanish ☐ Other _____

Address: _____ **City:** _____

County: _____ **Zip:** _____ **Phone:** _____

Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name:_____

Relationship to Beneficiary: _____ Phone: _____

Beneficiary currently resides: ☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility ☐ Group Home ☐ Special Care Unit (SCU) ☐ Other _____ D/C date (Hospital/SNF): ___/___/___

Change of Status: Non-Medical

SECTION E. CHANGE OF STATUS: NON-MEDICAL

Requested By (select one): ☐ PCS Provider ☐ Beneficiary

Responsible Party: ☐ Guardian ☐ Legal Power Of Attorney (POA) ☐ Family (Relationship): _____

Requestor Name: _____

PCS Provider NPI#: _____ PCS Provider Locator Code#: _____(three digit code)

Facility License # (if applicable): _____ License Date (if applicable): _____(mm/dd/yyyy)

Provider Contact Name: _____ Contact's Position: _____

Provider Phone_____ Provider Fax: _____

Email: _____

Reason for Change in Condition Requiring Reassessment:

☐ Change in beneficiary's location affecting ability to perform ADLs ☐ Change in caregiver status

☐ Change in days of need ☐ Other: _____

Describe the specific change in condition and its impact on the beneficiary's need for hands on assistance (required for all reasons):

Change of Provider

SECTION F. CHANGE OF PCS PROVIDER

Requested By (select one): ☐ Care Facility ☐ Beneficiary ☐ Other (Relationship to Beneficiary): _____

Requestor Contact's Name: _____ **Phone:** _____

Reason for Provider Change (select one)**:**

☐ Beneficiary or legal representative's choice

☐ Current provider unable to continuing providing services

☐ Other:_____

Status of PCS Services (select one)**:**

☐ Discharged/Transferred on _____(mm/dd/yyyy)

☐ Scheduled for discharge/transfer on _____(mm/dd/yyyy)

☐ Continue receiving services until beneficiary is established with a new provider agency; no discharge/transfer is planned

Beneficiary's Preferred Provider (select one):

☐ Home Care Agency	☐ Family Care Home	☐ Adult Care Home	☐ Adult Care Bed in Nursing Facility	☐ SLF-5600a	☐ SLF-5600c	☐ Special Care Unit

Agency Name:_____ Phone: _____

PCS Provider NPI#: _____ PCS Provider Locator Code#: _____(3 digit code)

Facility License # (if applicable): _____ License Date (if applicable): _____(mm/dd/yyyy)

Physical Address: _____