

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): ___/___/___

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 Status: Non-Medical

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: _____

Change of Provider