



State of Alaska • Department of Health and Social Services • Senior and Disabilities Services  
 Home and Community-Based Waiver Services  
 And  
 Personal Care Services  
**Change of Status: Provider Agency**

**Instructions** Check box for type of change, and provide required information. Send completed form and attachment to [DSDSCertification@alaska.gov](mailto:DSDSCertification@alaska.gov), or Fax to 907-754-3475, Attention: Provider Certification.

Name of provider agency \_\_\_\_\_

Provider number \_\_\_\_\_

Person to contact regarding change \_\_\_\_\_

Telephone number \_\_\_\_\_ Email \_\_\_\_\_

**New mailing address or contact information** (Required 10 Days prior to change).

Mailing address/City/Zip \_\_\_\_\_

Telephone number \_\_\_\_\_ FAX number \_\_\_\_\_

Cell number \_\_\_\_\_ Email \_\_\_\_\_

**New license for facility currently licensed under AS 47.32.** (Required upon issuance)

Attach copy of license showing changes regarding facility.

**New agency name or physical location** (Required 60 days prior to change).

For name change, attach new business license and if applicable, other licenses; new Certificate of Insurance showing name change; and any other documents, required for certification, that have been changed as result of the name change.

Services provided at this location       Services not provided at this location

Name of provider agency \_\_\_\_\_

Physical address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

**New form of business organization** (Required 60 days prior to change).

Attach new business license, and specify EIN/Tax number

- |                                                    |                                                 |
|----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Sole proprietorship       | <input type="checkbox"/> For-profit corporation |
| <input type="checkbox"/> General partnership       | <input type="checkbox"/> Non-profit corporation |
| <input type="checkbox"/> Limited liability company | <input type="checkbox"/> Limited partnership    |

**Agency sale/Change of ownership** (Required 60 days prior to change)

Purchaser/New owner name \_\_\_\_\_

Date of sale or change of ownership \_\_\_\_\_

**Agency closure** (Required 60 days prior to change).

Date of closure \_\_\_\_\_

Location of records/physical address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_  
 Owner/Administrator/Director signature

\_\_\_\_\_  
 Print name

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date