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, *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

☐ Sole proprietorship ☐ For-profit corporation

☐ General partnership ☐ Non-profit corporation

☐ Limited liability company ☐ 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