



State of Alaska • Department of Health and Social Service • Senior and Disabilities Services  
**Recipient Change of Status**

(\* **Note: This form is not for change in services.** Use UNI-03 *Plan of Care Amendment all Waivers* or PCA-03 *Personal Care Services Amendment to Service Plan* or CFC-01 *Amendment to Service Plan* to request change to service levels for Waiver, PCS and CFC/PCS programs.)

*This form is used to submit recipient status changes required to ensure program services and integrity. Only the care coordinator, recipient, or authorized agency representative recognized by SDS can submit for updates. All others please contact the care coordinator/agency for submission. Changes must be reported within 10 days per 7 AAC 100.900. Recipient obligation to report changes. A recipient eligible under 7 AAC 100.002(b), (d), (e) must report changes in accordance with 7 AAC 40.440. See also AS 47.05.010, AS 47.07.020, AS 47.07.040.*

- (1) Fill out the form completely; place N/A in any text box that is not applicable to the change being submitted.
- (2) Submit the form with any required documents

**By fax:** (Waiver) 907-269-3639 • (PCA) 907-269-8164 • (Fairbanks) 907-451-5046 •  
 (LTC) 907-269-3688 • (Grants) 907-465-1170 • (GR) 907-269-3648

**By DSM email or other encrypted email:** addressed to the applicable program

**By mail:** (Anchorage) 550 W 8<sup>th</sup> Avenue, Anchorage, AK 99501 •  
 (Fairbanks) 751 Old Richardson Hwy., Suite 100a, Fairbanks, AK 99701

Recipient Name \_\_\_\_\_ Recipient ID \_\_\_\_\_

Date change effective \_\_\_\_\_ Program \_\_\_\_\_

Person submitting form \_\_\_\_\_ E-Mail \_\_\_\_\_

Person submitting form/relationship to recipient \_\_\_\_\_

**Change of phone number**

Previous phone number \_\_\_\_\_ New phone number \_\_\_\_\_

Is this change of phone number also for the legal representative?      Yes      No

**Change of Physical Address**

Previous physical address \_\_\_\_\_ New physical address \_\_\_\_\_

Is this change of physical address also for the legal representative?      Yes      No

**Change of Mailing Address**

Previous mailing address \_\_\_\_\_ New mailing address \_\_\_\_\_

Is this change of mailing address also for the legal representative?      Yes      No

**Is this change of address to or from a licensed home?**      Yes      No

If Yes Name and Address of Licensed home \_\_\_\_\_

**Change of Legal Representative/Custody**  
(Include copy of legal representative document)

Previous legal representative/address

New legal representative/address

**Change of Recipient Name**  
(Include copy of legal document)

Previous name

New name

\_\_\_\_\_

\_\_\_\_\_

Reason for name change \_\_\_\_\_

**Admission or Discharge/Hospital or Long Term Care Facility**

Hospital or Facility Name \_\_\_\_\_

Date of admission  
\_\_\_\_\_

Estimated length of time hospitalized or estimated discharge date  
\_\_\_\_\_

Date of discharge  
\_\_\_\_\_

Discharged to                      Home                      Other location

If other location name (if applicable) and address of other location \_\_\_\_\_  
\_\_\_\_\_