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) 1835 Bragaw Street, Suite 350 Anchorage, AK 99508• (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