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|  | ASSISTED LIVING FACILITY (ALF) / ADULT FAMILY HOMES (AFH)**Adult Residential Care Services****Notice of a Change**To be completed by the facility. Please print. | CLIENT NAME: LAST FIRST MIDDLE INITIAL |
| SEX[ ]  Male [ ]  Female | DATE OF BIRTH |
| DSHS ACES CLIENT ID (REQUIRED FOR SUBMISSION) | PROVIDER ONE NUMBER |
| EFFECTIVE DATE OF ACTION |
| COMMENTS |
| **Section I. Type of Action** |
|  1. [ ]  Admission 2. [ ]  Discharge  3. [ ]  Deceased 4. [ ]  Social Leave; from  to * If exceeds 18 days in calendar year; from  to

 5. [ ]  Change in payment status (converting to Medicaid, etc.) |
| **Section II. Transfer / Discharge Information (Complete the following if Box 1 was checked)** |
|  1. [ ]  Home 2. [ ]  Hospital 3. [ ]  Nursing Facility 4. [ ]  Assisted Living 5. [ ]  Enhanced Services Facility 6. [ ]  Institution - DDA ICF-ID, DDA state facility (RHC) 7. [ ]  Adult Family Home 8. [ ]  Developmental Disabilities Group Home 9. [ ]  Hospice / Hospice Care Center 10. [ ]  Bed Holda. Discharge date: b. Return date: c. Other outcome:  11. [ ]  Other (specify):  |
| REASON FOR A DISCHARGE |
| COMMENTS |
| **Section III. Name of the Facility Report the Change** |
| NAME OF THE FACILITY | PHONE NUMBER (WITH AREA CODE) |
| STREET ADDRESS CITY STATE ZIP CODE |
| NAME OF THE PERSON REPORTING A CHANGE | SIGNATURE DATE  |
| **Section IV. Name of the New Facility** |
| NAME OF THE FACILITY | PHONE NUMBER (WITH AREA CODE) |
| STREET ADDRESS CITY STATE ZIP CODE |