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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 Hold  a. 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 | | | | | | |