IDAHO DEPARTMENT OF
HEALTH & WELFARE

NOTIFICATION OF CHANGE

Region:	DATE:
Regional Fax #: (208)	FROM AGENCY:
PARTICIPANT:	MID#:
AGENCY CONTACT:	
☐ PARTICIPANT IN SKILLED NURSING FACILITY DATE ENTERED:	
☐ PARTICIPANT IN RESIDENTIAL ASSISTED LIVING DATE ENTERED:	
☐ PARTICIPANT IN CERTIFIED FAMILY HOME DATE ENTERED:	
☐ PARTICIPANT HAS MOVED – DATE: NEW ADDRESS & PHONE #:	
☐ PARTICIPANT IN HOSPITAL – DATE:	
☐ PARTICIPANT DISCHARGED FROM HOSPITAL – DATE:	
☐ PARTICIPANT IS NO LONGER RECEIVING SERVICES • DATE & REASON: • LAST DATE SERVICE WAS PROVIDED:	
☐ OTHER:	
☐ MEDICAID RESPONSE IS REQUESTED. PLEASE CALL. RE:	