

Agency Change Form

Bureau of Long Term Care

Participant Name				Medicaid #	
Date		Region		IDHW Fax#	(208) 639-5731
Current Agency		Agency Contact		Agency Phone#	
New Agency		Agency Contact		Agency Phone#	
Reason for Change					
If Agency Change is due to an issue or complaint	(Please provide information and a Nurse Reviewer will contact the participant.)				

Agency Change requests received by the 25th of the month are effective the first day of the following month. Requests received after the 25th will not be effective until the first day of the second month.

Case by case exceptions for changes during the month will be considered by the Department for Instances of Fraud or Abuse by the caregiver, please provide information above.

Participant Signature		Date	
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After form is complete, please send form to:

FAX: (208) 639-5731

Email (Click Region Below)

[Region1](#) – [Region2](#) – [Region3](#) – [Region4](#) – [Region5](#) – [Region6](#) – [Region7](#)