



Notification of Change Form

Bureau of Long Term Care

Participant Name				Medicaid #	
Date		Region		Regional Fax#	(208)
Agency		Agency Contact		Agency Phone#	
	<input type="checkbox"/> Participant in Skilled Nursing Facility			Date Entered:	
	<input type="checkbox"/> Participant in Residential Assisted Living			Date Entered:	
	<input type="checkbox"/> Participant in hospital			Date Admitted:	
				Reason for Admission:	
	<input type="checkbox"/> Participant discharged from hospital			Date Discharged:	
	<input type="checkbox"/> Participant has moved			New Address:	
	Date Moved:			New Phone Number:	
	<input type="checkbox"/> Participant is no longer receiving services			Date Services Ended:	
				Reason Services Ended:	
Termination of participant services require a 14-day notification. 14-day termination rules do not apply to Non-Payment of Share of Cost or Caregiver Safety Risk. A narrative must be included for these instances.					
	<input type="checkbox"/> Caregiver Health & Safety Risk (Please Specify):			<input type="checkbox"/> Non-Payment by Participant	
	<input type="checkbox"/> Other (Please Specify):			<input type="checkbox"/> Medicaid response is required. (Please Specify):	

After form is complete, please send form to:

Email (Click Region Below):

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

Fax:

Region1 (208)666-6856 - Region2 (208)799-5167 - Region3 (208)454-7625 - Region4 (208)334-0953 - Region5 (208)736-2116 - Regions6 (208)239-6269 - Region7 (208)528-5756