IDAHO DEPARTMENT OF HEALTH & WELFARE

Significant Change Form

Bureau of Long Term Care

Purpose

This form is required to be submitted for any Significant Change resulting in an increase or decrease in the UAI Unmet need for participants receiving Aged and Disabled Services and Personal Care Services. For detailed information on Significant Change please review the Significant Change Form Instructions.

The Medicaid nurse reviewer will use this information to approve or deny significant change requests.

Participant Name				Medicaid #	
Provider Name				Provider #	
Date of Request		Date of Change		Anticipated Length of Change	
Justification	☐ Decrease in unmet need or available support			☐ Increase in unmet need or available support	
Overview Narrative for Change					

All areas of this form are required, or this document may be returned as denied. Please specify details related to the cause of the change in status for each appropriate area. If there is no change in an area, please mark No Change box for that section. Attach additional documentation that supports your observations if applicable and available. This may include attendant progress notes, supervising visit notes, the physician's history and physical, or office visit notes. For full instructions for completing Significant Change/Modification Request Form, please refer to document Significant Change/Modification Request Form Instructions and Sample. This document will provide information on how to fill out the form, update relevant information related to a participant's functional abilities, supports and needs.

PREPARING MEALS	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: ____________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
EATING MEALS	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: ____________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
TOILETING	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: ____________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
MOBILITY	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: ____________________ ☐ No Support ☐ No Change

Participant Name: ______________________________ Medicaid#: ______________________________

Provider Name: ______________________________ Provider#: ______________________________

Detailed narrative for change in abilities		
TRANSFERRING	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
PERSONAL HYGIENE	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
DRESSING	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
BATHING	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
ACCESS TO TRANSPORTATION	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
SHOPPING	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
LAUNDRY	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
HOUSEWORK	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
NIGHT NEEDS	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change

Participant Name: ______________________________ Medicaid#: ______________________________

Provider Name: ______________________________ Provider#: ______________________________

Detailed narrative for change in abilities		
MEDICATION	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
PSYCOLOGICAL / SOCIAL/ COGNATIVE FUNCTION	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
AREAS INCLUDE	Disorientation, Memory, Judgement, Hallucinations, Delusions, Anxiety, Depression, Wandering, Disruptive, Assaultive, Danger to Self, Alcohol/Drug Use, and/or Vulnerability.	
Detailed narrative for change in abilities		

Below area is reserved for significant changes for supplemental services (i.e.: Non-Medical Transportation, Chore Services, etc.)
Please specify the service in the top left box in addition to the available support and the detailed narrative.
(See Significant Change Form Instructions for a full list of supplemental services)

OTHER (Please Specify):	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
OTHER (Please Specify):	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: __________________ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		

Participant Signature		☐ Participant refused to sign		Date	
Provider Print Name		Provider Signature		Date	
RN Print Name		RN Signature		Date	

After form is complete, please fax form with cover sheet to:

Region1 & 2 (208)799-5167 – Region 3 & 4 (208)454-7625
Region 5 and 6 (208)239-6269 - Region7 (208)528-5756