IDAHO DEPARTMENT OF HEALTH & WELFARE

Notification of Change Form

Bureau of Long Term Care

Participant Name				Medicaid #	
Date		Region		Regional Fax#	(208)
Agency		Agency Contact		Agency Phone#	

	☐ Participant in Skilled Nursing Facility	Date Entered:
	☐ Participant in Residential Assisted Living	Date Entered:
	☐ Participant in hospital	Date Admitted: Reason for Admission:
	☐ Participant discharged from hospital	Date Discharged:
	☐ Participant has moved Date Moved:	New Address: New Phone Number:
	☐ 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.

	☐ Caregiver Health & Safety Risk (Please Specify):	☐ Non-Payment by Participant
	☐ Other (Please Specify):	☐ 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