Washington State Department of Social & Health Services
Transforming lives

ASSISTED LIVING FACILITY (ALF) /
ADULT FAMILY HOMES (AFH)

Adult Residential Care Services Notice of a Change

To be completed by the facility. Please print.

CLIENT NAME: LAST FIRST MIDDLE INITIAL	
SEX ☐ Male ☐ Female	DATE OF BIRTH
DSHS ACES CLIENT ID (REQUIRED FOR SUBMISSION)	PROVIDER ONE NUMBER

EFFECTIVE DATE OF ACTION

COMMENTS

Section I. Type of Action

1. ☐ Admission
2. ☐ Discharge
3. ☐ Deceased
4. ☐ Social Leave; from to
   - If exceeds 18 days in calendar year; from to
5. ☐ Change in payment status (converting to Medicaid, etc.)

Section II. Transfer / Discharge Information (Complete the following if Box 1 was checked)

1. ☐ Home
2. ☐ Hospital
3. ☐ Nursing Facility
4. ☐ Assisted Living
5. ☐ Enhanced Services Facility
6. ☐ Institution - DDA ICF-ID, DDA state facility (RHC)
7. ☐ Adult Family Home
8. ☐ Developmental Disabilities Group Home
9. ☐ Hospice / Hospice Care Center
10. ☐ Bed Hold
    a. Discharge date:
    b. Return date:
    c. Other outcome:
11. ☐ Other (specify):

REASON FOR A DISCHARGE

COMMENTS

Section III. Name of the Facility Report the Change

NAME OF THE FACILITY		PHONE NUMBER (WITH AREA CODE)
STREET ADDRESS	CITY	STATE ZIP CODE
NAME OF THE PERSON REPORTING A CHANGE	SIGNATURE	DATE

Section IV. Name of the New Facility

NAME OF THE FACILITY		PHONE NUMBER (WITH AREA CODE)
STREET ADDRESS	CITY	STATE ZIP CODE

This form is to be filled out and mailed to DMS, PO Box 45826, Olympia WA 98599-5826, or faxed to 855-635-8305.