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

ADULT RESIDENTIAL CARE SERVICES NOTICE OF ACTION

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
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Section IV. Name of the New Facility

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