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|  | ASSISTED LIVING FACILITY (ALF) /  ADULT FAMILY HOMES (AFH)  **Adult Residential Care Services**  **Notice of a Change** | | CLIENT NAME: LAST FIRST MIDDLE INITIAL | | |
| SEX  Male  Female | | DATE OF BIRTH |
| To be completed by the facility. Please print. | | DSHS ACES CLIENT ID (REQUIRED FOR SUBMISSION) | | PROVIDER ONE NUMBER |
| EFFECTIVE DATE OF ACTION | |
| **Section I. Type of Action** | | | | | |
| 1.  Admission  2.  Discharge  3.  Deceased  4.  Social Leave; from  to How many days has client used social leave thus far in this calendar year?  Is Social Leave ETR being requested in excess of 18 calendar days?  Yes  No  If Social Leave ETR is requested, how many additional days?  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 | | | | | |
| REASON FOR SOCIAL LEAVE | | | | | |
| PLAN FOR SOCIAL LEAVE (HOW WILL THE CLIENT’S PERSONAL CARE (MEDICATION MANAGEMENT) NEEDS BE MET WHILE THE CLIENT IS ON SOCIAL LEAVE)? | | | | | |
| 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 | | | | | |