



State of Alaska • Department of Health and Social Services • Senior and Disabilities Services  
Home and Community-based Waivers • Personal Care Services

## Report of Change: Provider Agency Information

**Instructions** Complete sections that apply and provide required information. Changes must be reported within required timelines as listed in the Provider Conditions of Participation. Send completed form and attachment to [DSDSCertification@alaska.gov](mailto:DSDSCertification@alaska.gov), or Fax to 907-754-3475, Attention: Provider Certification.

### Agency Information

Provider Agency Name: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Program Administrator: \_\_\_\_\_

Contact number: \_\_\_\_\_ Email: \_\_\_\_\_

**New license for facility currently licensed under AS 47.32** *(Required Residential licenses for family home habilitation, group home habilitation and residential supported living homes)*

### Required document

- Attach copy of license showing changes regarding facility *(Required upon issuance)*
- Cert-12 group home habilitation or Cert-13 family home habilitation site forms *(required 10 days prior to change)*

### New business mailing address or contact information *(Required 10 days prior to change)*

Date of change: \_\_\_\_\_

Mailing address/city/state/zip: \_\_\_\_\_

Business phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Business Email: \_\_\_\_\_ Business website: \_\_\_\_\_

### New business physical address *(Required 60 days prior to change)*

Date of change: \_\_\_\_\_

Services provided at this location

Service not provided at this location

Physical address/city/state/zip: \_\_\_\_\_

### Required documents listing new physical address

- Certificates of Insurance
- Additional attachments per service refer to Service Declarations (license, floor plans, permits, etc.)

### Ending certified service *(not agency closure)*

Name of service: \_\_\_\_\_ Medicaid#: \_\_\_\_\_

Date ending service: \_\_\_\_\_ Date Notice Provided to Recipients: \_\_\_\_\_

**New business name or organizational change** *(Required 60 days prior to change)*

Date of change: \_\_\_\_\_ New business name \_\_\_\_\_ New form of business organization \_\_\_\_\_  
New business name: \_\_\_\_\_ New EIN/Tax #: \_\_\_\_\_

**Select new business organization type**

Sole proprietorship

General partnership

Limited liability company

For-profit corporation

Non-profit corporation

Limited partnership

**List all owners of the above organization**

First Name	Last Name	% Ownership

**Required documents documenting change for business name and organizational change**

- Business license
- Certificates of Insurance

**Sale of Business (agency)** *(Required 60 days prior to change) \*Certification does not transfer to new owner, a new provider application is required*

Date of sale: \_\_\_\_\_  
Purchaser/New owner: \_\_\_\_\_ Contact #/email: \_\_\_\_\_

**Change of ownership** *(Required 60 days prior to change)**Only used if adding a new or removing an existing owner. If a complete ownership change, see Sale of business (agency)*

Date of change: \_\_\_\_\_ Add an additional owner \_\_\_\_\_ Remove an existing owner \_\_\_\_\_  
Name of owner changing: \_\_\_\_\_

**Business/agency closure** *(Required 60 days prior to change)*

Date of closure: \_\_\_\_\_ Date notice provided to recipients: \_\_\_\_\_  
Location of records (physical address/city/state zip): \_\_\_\_\_

**Additional Reminders**

- It is the certified agency/individual's responsibility to contact Conduent to update enrollment records directly, Contact Conduent at [AK-Enrollment@Conduent.com](mailto:AK-Enrollment@Conduent.com) or Fax to 907-646-4273
- Providers are responsible to update New Alaska Background Check system (NABCS)

\_\_\_\_\_  
Owner/Administrator/Director signature\_\_\_\_\_  
Print name\_\_\_\_\_  
Title\_\_\_\_\_  
Date