SECTION 1: Contact Information - THIS IS A REQUIRED FIELD.	
Legal Agency Name	**THIS IS A REQUIRED FIELD**. Enter the legal agency name as it appears on the business' Federal IRS documentation. This will be the entity name that is currently on file with MMAC.
DBA Name (if applicable)	Enter in the doing business name if the entity has one.
SSBG/GR Provider Number	This seven-digit number can be found on the agency's Participation Agreement for Home and Community Based Services in the Provider Number field.
NPI Number	**THIS IS A REQUIRED FIELD.** Enter the ten digit National Provider Identifier (NPI) number(s) that applies to the Contract Type chosen below.
Contract Type	**THIS IS A REQUIRED FIELD.** Check the contract type the proposed change applies to.
E-Mail Address	**THIS IS A REQUIRED FIELD.** Enter the e-mail address where the notification of approval/denial of the requested change can be sent.
SECTION 2: Main Office Changes	
Check the box(es) next to the type of change(s) being requested and fill in the new information for the MAIN office.	
Address Change	Enter or type the new address here. **Please note that if your business address is the same for both mailing and physical address, the new address must be listed on the next line also.**
Mailing, correspondence and remittance address	For changes to the mailing/correspondence and remittance address list the address where the business' mail will be delivered to if DHSS or DSS need to mail something to the provider. This could be remittance, paper checks, notices of revalidation, corrections needed, etc.
Phone Number Change	Please complete the boxes for phone number changes as applicable.
Fax Number Change	If changing the fax number, list the most current fax number for your business.
Change e-mail address	To change an e-mail address list the e-mail address and mark which box the e-mail address applies to: Business, Director, Designated Manager, CDS Coordinator or RN Supervisor.
Change main office days/hours of operation	To change the main office days and hours of operation, list the days and hours in the box. By appointment only is not allowed by MMAC/DHSS. For satellite office days/hours of operation, see **section 3** below on the change request form.
Change Electronic Visit Vendor (EVV-Telephony)	Enter in the name of the vendor on the form. Attach documentation with the request such as a contract or receipt of service contract.

Section 3: Satellite Offices	
Modify A Location	Mark this box if modification to a satellite office is needed and list modifications in the box as applicable. If more space is needed, see section 8 on the last page.
Close A Location	List the date of closure Check the box whether or not you currently have participants served by the office closing If NO is checked – the counties listed under that office will be removed from the record. If YES is checked – list the office MMAC will transfer the counties to.
Open A Location	**Physical Satellite Location** - List the physical address of the satellite office.
	Mailing Address - List the address that correspondence from DHSS/MMAC/DSS will be sent to for this office.
	Main Phone - List the office phone number for this location.
	Fax - List the Fax number for this location.
	Emergency Phone - List the emergency phone number for this location, where clients/DHSS/MMAC/DSS can reach the business during hours outside the normal business hours of this location
	Days/Hours of Operation - List the days and hours that this location will be open. Someone must be in this office during the business hours listed on this form unless proper notice is given (a sign, voicemail etc must reflect any out of the ordinary changes).
	Counties Served By This Office - List the counties that this office will serve. A Service Area Commitment form will be required. https://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/provider-contracts-forms/ **Please note MMAC will not add any counties that are further than a 100 mile radius of the office location listed.**
	Contact Person For This Office - List the person who will be the point of contact for this office. AT MINIMUM for this person, their full name, any aliases, their SSN, date of birth, date of hire and license number if applicable as well as an FCSR screening within the past year must be submitted. https://health.mo.gov/safety/fcsr/ **Please check and complete Section 4 of the form if the person is a director, designated manager, cds coordinator or an RN supervisor for this location. Attach any documentation listed in that section for that person**.

Section 4: Staff Changes (left to right)	
Change in Director	Mark the box to the left. Enter in the director's name, date of birth, SSN and the office that they will be located at during posted business hours. **The following will be required. Attach on a separate sheet as necessary:** **- A current copy of the person's FCSR** **- Any aliases for the director** **- Date of hire**
Change in IHS Designated Manager	Mark the box to the left. Enter in the designated manager's name, date of birth, SSN and the office that they will be located at during posted business hours. The following will be required. Attach on a separate sheet as necessary: **- A current copy of the person's FCSR** **- Any aliases for the designated manager** **- Copy of licensure** **- Copy of degree/training** **- Copy of Provider Certification Training** **- Copy of Resume and Employee Application** **- Date of hire**
Change in CDS Coordinator	Mark the box to the left. Enter in the CDS coordinator's name, date of birth, SSN and the office that they will be located at during posted business hours. The following will be required. Attach on a separate sheet as necessary: - **A current copy of the person's FCSR** **- Any aliases for the CDS coordinator** **- Date of hire**
Change in IHS/ADC RN Supervisor	Mark the box to the left. Enter in the RN Supervisor's name, date of birth, SSN and the office that they will be located at during posted business hours. The following will be required. Attach on a separate sheet as necessary: **- A current copy of the person's FCSR** **- Copy of licensure** **- Copy of degree/training** **- Copy of Resume and Employee Application** **- Any aliases for the RN Supervisor** **- Date of hire**
Staff Name Change	For name changes of staff enter in the person's previous name (first and last). Enter in the person's new name (first and last). Mark the box below as applicable – director, designated manager, CDS coordinator, or RN supervisor. The following MUST be attached: - **A copy of marriage certificate, divorce documentation showing name change, or social security card with current name listed** - **A copy of RN licensure if applicable** - **A copy current copy of the person's FCSR with their new legal name on it.**

Section 5: Counties & Services (Left to Right)	
Add Counties	List the counties that need to be added. If there are any satellite offices, list the address/office location that the counties need to be added to. A Service Area Commitment form will be required. https://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/provider-contracts-forms/ **Please note that MMAC will not add counties that are more than 100 miles from the office location to the center of a requested county unless warranted on a case by case basis.**
Remove Counties	Check the box whether or not you currently have participants served in the counties being removed. If NO is checked – the counties listed under that office will be removed from the record. If YES is checked – list the office MMAC will transfer the counties to. A Service Area Commitment form will be required. https://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/provider-contracts-forms/
Add Services	List the service(s) requested to be added to the Service Area Commitment. If requesting Advanced Personal Care (APC) be added, an APC training plan and an APC Addendum must be attached. https://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/provider-contracts-forms/
Remove Services	List the service(s) requested to be removed from the Service Area Commitment.
Section 6: Voluntarily Terminate Enrollment	
Voluntarily Terminate	Check the box that you wish to voluntarily terminate enrollment with MO HealthNet effective month, day, and year. Enter the future contact person's name Enter the future contact person's phone number Enter the future contact person's e-mail address **Submit the following:** 1) A letter stating that you wish to terminate your enrollment with MO HealthNet – include your NPI in the letter. 2) A copy of the letter that you sent to the Department of Health and Senior Services letting them know that you will be terminating your enrollment with MO HealthNet. 3) A copy of the letter that was sent to the participants letting them know that you will be terminating your enrollment and that they will need to find a new provider. 4) List of Medicaid Participants serviced from your entity. 5) List the Location where records will be stored at for 5 years after the date of termination listed above (city/state/zip)

Section 7: Change in Entity/Agency Name, EIN, NPI or Ownership	
Agency Name Changing To	Mark the box to the left and enter the NEW business name as it is registered with the IRS. **Submit the following:** 1) Attach an original, signed letter on the agency's letterhead explaining in detail the type of change requested and the reason. 2) Attach a copy of the letter sent to participants notifying them of the change. 3) Copy of the Federal Tax ID number notification from the IRS that includes the new agency name. 4) Copy of the ADC, RCF, or ALF license under the new name (if applicable). 5) Provider/Vendor Profile Form – Use the correct form for your provider type. 6) Business Organizational Structure form and all documents indicated under the Section completed on the form. List all managing employees and owners with full name, SSN and date of birth. 7) DSS-MMAC EFT Form 8) For in-home services providers, Certificate of Insurance and Employee Dishonesty Bond issued in the new name. 9) Documentation from CMS NPPES with NPI information for new agency name. 10) List of Medicaid Participants serviced from your entity.
Change In Federal Tax ID (FEIN) or NPI – Ownership remains the same	Mark the box to the left. If changing EIN, enter in the new EIN and the previous EIN. If changing NPI, enter in the new NPI and the previous NPI. **Submit the following:** 1) Attach an original, signed letter on the agency's letterhead explaining in detail the type of change requested and the reason. 2) Copy of the Federal Tax ID number notification from the IRS that includes the new agency name 3) DSS-MMAC EFT Form 4) Copy of current NPPES letter if changing NPI 5) List of Medicaid Participants serviced from your entity.

Sale/Transfer of Assets or Change of Ownership	Mark the box to the left. Enter in the seller's name. Enter in the buyer's name. Enter in the buyer's contact person and phone number. Enter in the buyer's mailing address including city/state/zip. List the date the selling provider will cease business List the effective date of the sale **Submit the following:** 1) Attach an original, signed letter on the agency's letterhead explaining in detail the type of change requested and the reason. 2) Attach a copy of the letter sent to participants notifying them of the change. 2) Business Organizational Structure form and all documents indicated under the Section completed on the form. List all managing employees and owners with full name, SSN and date of birth. 3) A current FCSR for all Designated Managers, Coordinators, Directors, and RNs. (https://health.mo.gov/safety/fcsr/) 5) Provider/Vendor Profile Form – Use the correct form for your provider type. 6) List of Medicaid Participants serviced from your entity.
Section 8: Comments	
Comments	Provide additional comments or information on requested changes. Other requested change not indicated on the form should be explained in this section.
Signature	The form must be signed by a representative authorized to make changes on behalf of the agency. The typed or printed name and title of the person signing must be included. **ELECTRONIC SIGNATURE** is not acceptable.
Submission of Form	**All 4 pages must be received. The request will be automatically rejected if not all 4 pages are received.** Submit the entire form along with all required documentation as indicated in the section(s) completed to the fax number listed on the form – 573-634-3105. **If this is an URGENT request, please call or e-mail us to let us know. Urgent requests will be reviewed on a case by case basis.** 573-751-3399 – mmac.ihscontracts@dss.mo.gov