STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE
HOME AND COMMUNITY BASED SERVICES CHANGE REQUEST

SECTION 1: PROVIDER INFORMATION – COMPLETE ALL APPLICABLE FIELDS IN A LEGIBLE MANNER. Please complete ONE form per provider EIN. THIS IS A REQUIRED SECTION.

LEGAL AGENCY NAME AS IT APPEARS WITH THE IRS:

DOING BUSINESS AS NAME (IF APPLICABLE):

NPI:	**SSBG (optional):**

☐ CDS	☐ In-Home	☐ Reassessments	☐ Adult Daycare	☐ RCF (Residential Care)	☐ ALF (Assisted Living)

EMAIL ADDRESS FOR CONFIRMATION OF CHANGES:

SECTION 2: MAIN OFFICE CHANGES

☐ ***ADDRESS CHANGE*** – **Submit a business license and lease agreement or deed. Explain in Section 8 if not applicable.**

Main Physical Address
address city state zip

Remittance/Mailing Address:
address city state zip

☐ ***PHONE NUMBER CHANGES*** – **complete the sections below as applicable:**

BUSINESS:	DIRECTOR:
DESIGNATED MANAGER:	CDS COORDINATOR:
RN SUPERVISOR:	EMERGENCY:

☐ ***FAX NUMBER CHANGE*** – **list here:**

☐ ***EMAIL ADDRESS CHANGE*** **– list below. May use Section 6 or another sheet to report more than 1 e-mail change:**

- ☐ **ALL** _____
- ☐ **Business** _____
- ☐ **HCBS Care Plans** _____
- ☐ **Director** _____
- ☐ **RN Supervisor** _____

☐ **CHANGE MAIN OFFICE DAYS/HOURS OF OPERATION by appointment not allowed.**
The minimum allowed is 3 days/week - 4 hrs/day between 8am-5pm

- ☐**Mon** _____
- ☐**Tues** _____
- ☐**Wed** _____
- ☐**Thu** _____
- ☐**Fri** _____

SECTION 3: SATELLITE OFFICE CHANGES

☐ ***MODIFY A SATELLITE OFFICE*** – **LIST WHICH OFFICE ON FILE IS BEING UPDATED HERE:**

address city state zip

☐ **MOVING TO (Submit a copy of lease agreement or deed and business license):**

address city state zip

☐ **MAILING ADDRESS:**

address city state zip

☐ **PHONE NUMBER:**

☐ **E-MAIL ADDRESS:**

☐ **FAX NUMBER:**

☐ **DAYS/HOURS OF OPERATION**

☐**Mon** _____ ☐**Tues**_____

☐**Wed** _____ ☐**Thu** _____

☐**Fri** _____

☐ **CONTACT PERSON – see section 4**

☐ ***CLOSE A SATELLITE LOCATION***

OFFICE ADDRESS CLOSING:

address city state zip

ADDRESS OF WHERE RECORDS WILL BE KEPT FOR 6 YEARS:

address city state zip

DATE OF CLOSURE (MM/DD/YYY):

Does the business have participants in any of the counties that were served by this office? ☐YES ☐ NO

If YES above, list which office/s the counties served by this office need to be transferred to:

address city state zip

☐ ***OPEN A LOCATION*** **Submit a copy of lease agreement or deed and business license**

PHYSICAL ADDRESS:

address city state zip

MAILING ADDRESS:

address city state zip

E-MAIL ADDRESS:

PHONE NUMBER:

☐ **DAYS/HOURS OF OPERATION**

☐**Mon** _____ ☐**Tues** _____

☐**Wed** _____ ☐**Thu** _____

☐**Fri** _____

Counties served by this location – LIST IN SECTION 6 – ATTACH A COMMITMENT FORM

Contact Person for this office: – a current FCSR is required to be sent with the request.

Full Name:	Date of Birth:	SSN:
Title:		Date of Hire:

SECTION 4: STAFF CHANGES – A CURRENT FCSR MUST BE SUBMITTED

☐ **Update contact person for a satellite office - a current FCSR is required**

Name:

Date of birth:	SSN:	Date of hire:

☐	**DIRECTOR NAME:**		☐	**CDS COORDINATOR NAME:**	
	Date of birth:	SSN:		Date of birth:	SSN:
	Office address:			Office address:	
	Date of Hire:			Date of Hire:	
☐	**IHS DESIGNATED MANAGER NAME:**		☐	**IHS RN SUPERVISOR NAME:**	
	Date of birth:	SSN:		Date of birth:	SSN:
	Office address:			Office address:	
	Date of Hire:			Date of Hire:	
	THE FOLLOWING MUST BE ATTACHED: - Copy of licensure or degree - Copy of Provider Certification Training - Copy of Resume			**THE FOLLOWING MUST BE ATTACHED:** - Copy of licensure - Copy of employment application	

SECTION 5: COUNTIES & SERVICES

☐ ***ADD COUNTIES*** – **list in section 6 - attach a service area commitment form**

Does the business entity have pending participants in any of the counties being requested? ☐ **YES** ☐ **NO**

☐ ***REMOVE COUNTIES*** – **list in section 6 - attach a service area commitment form**

Does the business entity have participants in any of the counties being removed? ☐ **YES** ☐ **NO**

☐ ***ADD SERVICES*** – attach a commitment form - for **advanced personal care** attach an APC Addendum & a training plan

☐ ***REMOVE SERVICES*** – list in section 6 and attach a commitment form

SECTION 6: NOTES – ANYTHING NOT REFERENCED IN ANY SECTION ABOVE. **PLEASE BE DESCRIPTIVE.**

THE AUTHORIZED SIGNER VERIFIES THAT HE/SHE IS AUTHORIZED TO EXECUTE THIS CHANGE REQUEST DOCUMENT ON BEHALF OF THE PROVIDER/VENDOR UNDER AUTHORITY GRANTED BY SAID PROVIDER/VENDOR.

(Original Signature) **Electronic signature is not acceptable.**	**Date:**
TYPE OR PRINT NAME OF AUTHORIZED PERSON SIGNING:	**TYPE OR PRINT TITLE OF AUTHORIZED SIGNER:**

PLEASE FAX FORM & ALL DOCUMENTS TO 573-634-3105. Please do not e-mail your request.

MISSOURI MEDICAID AUDIT AND COMPLIANCE USE ONLY BELOW:

☐ APPROVED ☐ REJECTED

ENTERED IN/VERIFIED : ☐ HCSPS ☐ MMIS ☐ LEX/NEX ☐ SITE VISIT APPROVED

COMMENTS:

CLERK ID/SIGNATURE:	**DATE:**