ASSISTED LIVING FACILITY (ALF)
FINANCIAL CHANGE AGREEMENT

FACILITY NAME:_____ **CONTRACTOR NAME:**_____

MEMBER NAME:_____ **AHCCCS ID:**_____

THE FOLLOWING BILLING/MEMBER LOC CHANGE(S) HAVE OCCURRED

		Rate:	Effective:
I. Facility Reimbursement:	LOC_____	$_____	_____
II. Level of Care (LOC) Changed to:	_____	$_____	_____
III. Member Room & Board Responsibility		$_____	_____

I HAVE READ AND AGREE WITH THE ABOVE CHANGES.

FACILITY REPRESENTATIVE:

Printed _____ Title: _____

Signature _____ Date: _____

MEMBER / REPRESENTATIVE: (ONLY REQUIRED FOR CHANGES IN ROOM & BOARD)

Printed _____ Relationship: _____

Signature _____ Date: _____

CASE MANAGER:

Printed _____

Signature _____ Date: _____

A SIGNED COPY MUST BE PROVIDED TO THE CONTRACTOR'S CASE MANAGER FOR THE MEMBER'S FILE

Effective Dates: 10/01/17
Revision Dates: 07/25/17