



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, 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

Date of sale: _____

Purchaser/New owner: _____ Contact #/email: _____

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 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