pennsylvania
DEPARTMENT OF HUMAN SERVICES

Domiciliary Care/Personal Care Home Supplement
Change/Discontinue Form

INSTRUCTIONS: This form is prepared by the placement agency to communicate a change in the consumer's circumstances (improvement in functioning, move, hospitalization, death, etc.) to the county assistance office (CAO). Fill in the consumer's identifying information. Complete #1 if the consumer no longer needs the Domiciliary Care/Personal Care Home (PCH) supplement. Complete #2 if the consumer has moved from a Domiciliary Care/PCH to another Domiciliary Care/PCH provider and continues to need the supplement. Enter the placement agency information at the bottom of the form along with the signature of the individual completing the form. Send the original form to the CAO and retain a copy for the placement agency.

TO:	NAME:	
	SSN:	MA ID #:
	ADDRESS OF FACILITY:	
	CITY OR TOWN:	
	STATE:	ZIP CODE

1. Individual no longer needs Domiciliary Care/PCH Supplement effective: _____ (DATE)

Reason:

- ☐ A. Improved functioning
- ☐ B. Change in living arrangements:
  - ☐ 1. Now in a Long Term Care facility:
    - Facility name: _____
    - Address: _____
  - ☐ 2. Other living arrangement:
    - Home name (if applicable): _____
    - Address: _____
- ☐ C. Death
- ☐ D. Other (specify):

_____

_____

2. Individual moved from previous Domiciliary Care/PCH on: _____ (DATE) to:

Domiciliary Care/PCH Name (if applicable): _____

Address: _____

PLACEMENT AGENCY:	
ADDRESS:	
AGENCY CONTACT:	
TELEPHONE:	
SIGNATURE:	DATE: