

CHOICES FOR CARE
Clinical Certification and/or Highest Paid Provider Change Form

Participant Name: _____

SSN: _____

Section A: Clinical Change

- ❖ **Previous Clinical Status** Highest High
- ❖ **NEW Clinical Status** Highest High
- ❖ **Effective Date:** _____

Section B: Highest Paid Provider Change

- ❖ **Previous Highest Paid Provider** _____
- ❖ **NEW Highest Paid Provider** _____
- ❖ **Effective Date:** _____

DAIL LTCCC: _____

DATE: _____

Please make any necessary changes in ACCESS to clinical level of care or patient share. If a patient share, send notice to the Choices for Care Participant and Highest Paid Provider.

(Yellow copy to DCF/ESD D.O., Original to DAIL File)