COMMMUNITY CARE NOTIFICATION FORM (CCNF), FORM 6500

(Complete all the information below; this is needed for correct entry into our system)

1. **Mark (X) the appropriate box to indicate the reason for sending CCNF:**
☐ Initial ☐ Change ☐ Complaint/Concern ☐ Transfer ☐ Discharge ☐ Other

2. **To:** _____ **Date:** _____

3. **From:** _____ **Telephone:** _____
(Agency Name)

4. **Client Name:** _____ **Medicaid #:** _____ **AIMS ID:** _____

☐ **Mark if new address** **Client Address:** _____

City: _____ **Zip:** **County:** **Telephone:** ☐ **New Number**

5. **SERVICES:** ☐ PSS ☐ PSSX ☐ ERS ☐ ALS ☐ ADH (☐ HALF, ☐FULL)(☐LEVEL I, ☐ LEVEL II) ☐ HDM
☐ SNS (☐ RN, ☐ LPN) ☐ HDS ☐ OHR **COMMENTS:** _____

6. **Date your RN/Staff completed initial evaluation with client:** ***(Must be RN for ALS, ADH and PSS/X)***
☐ **Services were accepted** ☐ **Services were not accepted – REASON:** _____

7. **Date services began:** ***(Please fill in frequency grid below #12 for PSS, PSSX, ADH, MEALS (delivery day and quantity))***

8. **Service issues: (Check below and clarify in #13 please)**
☐ Request service increase ☐ Failure to pay cost share ☐ Fall/Incident
☐ Request service decrease ☐ Client termination ☐ Client had ER visit, WHERE
☐ Requested provider change ☐ Health/Safety issue ☐ Client in hospital, NAME
☐ Request for information ☐ Client out of home
☐ Other: _____

9. **Discharge (briefly describe actions leading up to need for discharge process):** _____

10. **Date discharge (30-day) letter sent** **Actual discharge date** **Last day of service**

11. **Are services continuing through 30-day notice?** ☐ Yes ☐ No ***Please enter final monthly units below***
FINAL UNITS **PSS** **PSSX** **ADH** **ERS** **HDM** **ALS** **RN** **LPN** **OHR**

12. **SERVICE FREQUENCY:** ☐ Weekly ☐ Monthly ☐Bi-Monthly

INITIAL OR CURRENT SERVICES IN HOME

WEEKDAY	UNITS ONCE DAILY	AM UNITS	PM UNITS	BEGIN DATE	END DATE
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					

UNIT CHANGE

WEEKDAY	UNITS ONCE DAILY	AM UNITS	PM UNITS	BEGIN DATE	END DATE
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					

13. **If complaint or concern, be specific**

14. **Sender name or signature:** **Title:** **Date:**

15. **Recipient name or signature:** **Title:** **Date:**

16. **Recipient response:** _____