### Assisted Living Facility (ALF) Financial Change Agreement

**Facility Name:** __________________________  **Contractor Name:** __________________________

**Member Name:** __________________________  **AHCCCS ID:** __________________________

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### The Following Billing/Member LOC Change(s) Have Occurred

<table>
<thead>
<tr>
<th>Rate:</th>
<th>Effective:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Facility Reimbursement: LOC_____</td>
<td>$__________</td>
</tr>
<tr>
<td>II. Level of Care (LOC) Changed to:</td>
<td>$__________</td>
</tr>
<tr>
<td>III. Member Room &amp; Board Responsibility</td>
<td>$__________</td>
</tr>
</tbody>
</table>

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**I have read and agree with the above changes.**

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**Facility Representative:**

Printed ____________________________  **Title:** __________________________

Signature ____________________________  **Date:** __________________________

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**Member / Representative:** (only required for changes in Room & Board)

Printed ____________________________  **Relationship:** __________________________

Signature ____________________________  **Date:** __________________________

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**Case Manager:**

Printed ____________________________

Signature ____________________________  **Date:** __________________________

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**A signed copy must be provided to the Contractor’s Case Manager for the Member’s file**