DOMICILIARY CARE
REDETERMINATION REPORT

INSTRUCTIONS: This report is prepared by the placement agency following a planned redetermination of need for Domiciliary Care or a change in the consumer's circumstances (moved, hospitalization, death, etc.). Make a copy of the report for the placement agency's records. The original is sent to the County Assistance Office. Fill in all identifying information. – Enter date the need for Domiciliary Care was redetermined. – Check appropriate blocks below. If Block #2 is checked, provide the date and check either block #2a, #2b, #2c, or #2d. Check Block #3 only if the individual moves from a Domiciliary Care home to either another Domiciliary Care or Personal Care Home and continues to need the State Supplement. – Complete placement agency information at the bottom of the form.

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

This is to certify that the need of the above named individual for Domiciliary Care was reevaluated on _____
DATE

The results of this determination are:

1. ☐ Need for Domiciliary Care continues and individual remains in certified Domiciliary Care Facility.

2. ☐ Person no longer needs Domiciliary Care 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)
_____
_____

3. ☐ Person moved from previous Domiciliary Care Home on _____ to:
DATE

Domiciliary Care/PCH Name (if applicable): _____
Address: _____
_____

PLACEMENT AGENCY: _____

ADDRESS: _____

AGENCY CONTACT: _____

TELEPHONE #: _____