

# Arkansas Total Care Provider Change Choice Form

For Home- and Community-Based Services (HCBS),  
Home Health, and/or Personal Care



Member Name (Last Name, First): \_\_\_\_\_

Member ID #: \_\_\_\_\_ Member DOB: \_\_\_\_\_

**Member:** I am requesting services from an HCBS, personal care, and/or home health provider. I have the right to choose an agency to give these services to me or my child. Unless Arkansas Total Care makes an exception for me, I can only get HCBS, personal care, and/or home health services from one provider. I have the right to change my provider if I am not happy with the services I get from them. I know that I can talk with my Care Coordinator if I need help finding an HCBS, personal care, and/or home health provider.

**I have chosen the below HCBS, personal care, and/or home health provider for me or my child.**

Provider Name	Phone
Contact Name	
Address	Service Start Date

By signing this form, I understand that I have chosen to get services from this provider. I acknowledge that it is my responsibility to let my previous provider know so they can coordinate my care with my new provider. I understand that I am free to choose any HCBS, personal care, and/or home health provider in my health plan's network.

Member/Legal Guardian Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

Printed Legal Guardian Name (if applicable): \_\_\_\_\_

**Provider:** A Member Choice Form is required prior to rendering any HCBS, personal care, and/or home health to a member who is changing providers. This form must be filled out in its entirety to be accepted. The provider is responsible for coordinating the transition of care with the member's previous provider prior to starting any services.

Provider Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_