ADHS/DBHS
Policy Form 402.1, Notification of Changes to the Network

Date of Notification to T/RBHA:		**Date of Notification to ADHS/DBHS:**	
Current Provider Billing Type:		**Description:**	
T/RBHA Name:		**Agency Name:**	
Services/Program CURRENTLY Offered:			
Site Location *(Current Address)*:			
	Street Address	***City***	***State*** / ***Zip Code***
Transition Contact:			
	Name	***Title***	***Email*** / ***Phone***
Choose One:	☐ **RBHA INITIATED**	☐ **PROVIDER INITIATED**	
Type of Change:	☐ **Site Move** ☐ **Change in Licensure**	☐ **Site Closure** ☐ **New Site – *(Identify new address below)*** ☐ **Other – Please Describe:**	
Briefly Describe Change:			
Effective Date of Change:			
Reason for Change:			
Anticipated Impact of System of Care:			
Program Population Impacted:			
Number of TXIX/XXI & NTXIX/XXI Members Effected in Each Program Category:			
No. of Staff Impacted (Specify Roles):			

If a site move, please include the following:

Address of NEW Site Location:			
	Street Address	***City***	***State*** / ***Zip Code***
Distance of Move:		**Bus Availability/ Other Transportation Availability:**	

Please include the following additional information, if applicable:

Planned Date of Notification to Members:	
Copy of All Correspondence and Notification Attached (Please List):	
Transition Plan:	
Other:	

SUBMIT COMPLETED DOCUMENT TO: BHSnetworkmanagement@azdhs.gov and BHSContractCompliance@azdhs.gov
REMINDER: T/RBHAs must submit a "Member Notification Letter" to ADHS/DBHS Policy Dept. for approval at PolicyUnit@azdhs.gov