STAFF CHANGE NOTIFICATION FORM
DIVISION OF Home and Community Based Care
HOME HEALTH

The Division of Home and Community Based Care must be notified each time a facility has a change to the following positions: Clinical Supervisor, Alternate Clinical Supervisor, Administrator, and Alternate Administrator. Please complete this form and submit it to the Division in the event of a change. Please email the completed form to**: hcbc@health.in.gov.**

Facility License or Provider Number:
Facility Name:
Facility Address:
City / State / Zip:

PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW TO MATCH THE CORRECT POSITION CHANGE TYPE ☐

Effective Date of change:	
☐**ADMINISTRATOR (New)**	☐**CLINICAL SUPERVISOR (New)**
☐**ALTERNATE ADMINISTRATOR (New)**	☐**ALTERNATE CLINICAL SUPERVISOR (New)**

Name:	**Date Appointed:**
Resume included☐	**Criminal history report included**☐
License included, if required ☐	

PREVIOUS STAFF (PERSON LEAVING POSITION ABOVE)

NAME:
LAST DATE IN POSITION:

Please complete and email the form to: hcbc@health.in.gov.

Mail to the following address:

Indiana Department of Health
HCBC/ Home Health 2 North
Meridian, Section 4B
Indianapolis, IN 46204