



## Long-Term Care Level of Care Change

Please Print

Facility Information		
Name of Facility	Location of Facility	Facility Number

Resident Information					
Name of Resident (Surname, Given, Initial)		<b>Date of Change:</b>	Year	Month	Day
Health Services Number	Out-of-Province Health Card - state province	New Level of care:			
		<input type="checkbox"/> 1	<b>If Level 4:</b>	<input type="checkbox"/> 4a	
		<input type="checkbox"/> 2		<input type="checkbox"/> 4b	
		<input type="checkbox"/> 3		<input type="checkbox"/> 4c	

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Authorized Official

Health 31-7779/298