

# Change of Agency Form

Notification Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

PMI# \_\_\_\_\_ HMO# \_\_\_\_\_

I hereby notifying \_\_\_\_\_

to terminate my services effective on this date \_\_\_\_\_ at 11:59 PM.

Effective date of \_\_\_\_\_ my services will be billed through  
the new agency, Rainbow Home Healthcare, Inc.

Client/Responsible Party (Print Name) \_\_\_\_\_

\_\_\_\_\_  
Client/Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date