

**Temporary Emergency Relocation Form**

**(for non-DHSR Licensed Services)**

**Submit fully completed form to:** providernetwork@alliancehealthplan.org

**Provider Name**: Click or tap here to enter text.

**Date form submitted:** Click or tap here to enter text.

**Name of person submitting form:** Click or tap here to enter text.

**Phone:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

**Any additional provider staff that needs to be contacted (include phone number and email):** Click or tap here to enter text.

**Contracted Address of site that needs to be temporarily relocated:** Click or tap here to enter text.

**Temporary Relocation Information**

Address: Click or tap here to enter text.

Phone Number: Email: Click or tap here to enter text.

Services to be provided in temporary relocation site:

[ ]  All services currently contracted at affected site

[ ]  Other (list services that you plan to provide at the temporary site): Click or tap here to enter text.

**Action Plan**

Provide an explanation and rationale for evacuating the site and moving services to a new location. Click or tap here to enter text.

When do you anticipate moving the services back to the site? Click or tap here to enter text.

If the site can’t be used due to damage what is the anticipated plan? Click or tap here to enter text.

Provide an explanation of how services and operations will continue at the temporary location: Click or tap here to enter text.

Have any medical records containing personal health information been destroyed? Click or tap here to enter text.

If so, what is your plan for informing Alliance, member and/or guardian? Click or tap here to enter text.