MEDICAL ASSISTANCE DIVISION
PERSONAL CARE TRANSFER/CLOSURE FORM

Date: ____/____/____

Consumer Name: ____ Consumer Date of Birth: ___________

TRANSFER

You are currently receiving Personal Care Services through: ____.
You have indicated that you want to change your Personal Care Agency to: ______________________________.
The reason you would like to transfer agencies is because:

____

____

The agreed date of the transfer is _________________________. By signing this form, all parties agree the above to be true and agree to this transfer. If someone other than the consumer is initiating the transfer, the Personal Care Agency must have verification on file that the person is the consumer's legal representative. All signatures must be present to validate the transfer.

______________________________	____/____/____	______________________________________	
Consumer/Legal Guardian Signature	Date	Consumer's Street Address	
______________________________		______________________________________	
Consumer/Legal Guardian's Phone #		City, State, Zip	
______________________________	_____________	_______________________	____/____/____
Receiving Agency Name	Provider Phone #	Agency Signature	Date

CLOSURE

____
Reason

______________________________	_____________	_______________________	____/____/____
Agency Name	Provider Number	Agency Signature	Date

If you have any questions about Personal Care, you may contact your assigned Managed Care Organization (MCO).

TO BE FILLED OUT BY THE MCO ONLY

____/____/____	____/____/____	____/____/____	____________________	______________
Review Date	Effective Date	Expiration Date	Authorization Number	MCO

MCO Care Coordinator name:____.

Date copy of completed transfer form sent to the ***originating*** agency ____/____/_____.

Date copy of completed transfer form sent to the r***eceiving*** agency ____/____/_____.

Date ending authorization sent to the ***originating*** agency ____/____/_____.