**WAIVER TRANSFER FORM**

1.**Prior Authorization Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Expiration Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3.Other Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. Transfer Type:

ICWP to ICWP [ ]  ICWP to SOURCE [ ]  ICWP to CCSP [ ]

 **5. Member transfer from**: Agency Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Provider ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Care Coordination/Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last Service Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Member current waiver type (circle one) CCSP SOURCE ICWP

 Member street address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_

 Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 6. **Member transfer to**: Agency Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Provider ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Care Coordination/Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 New waiver type (circle one) CCSP SOURCE ICWP

 Member new street address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_

 Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#  WAIVER TRANSFER FORM

**Instructions**

Independent Care Waiver Program

*Purpose:* The waiver transfer form is used to transfer case records from one waiver to another and also to notify Alliant of the transfer.

*Who Completes/When Completed:* The ICWP case manager completes the member transfer form for a member that is being discharged from her agency to another waiver such as Source or CCSP. It accompanies the original case record of the last year of service to the receiving agency. Original agency is also responsible for notifying Alliant by attaching this form and supporting documentation of reason for transfer and client agreement of such. This is attached to the “Contact Us”.

*Instructions:*

* 1. Enter the Member’s Prior Authorization number and expiration date.
	2. Enter the Member’s name (last name, first, and middle initial), DOB, SS# and Mdcd ID #
	3. Enter other contact information
	4. Enter the type of transfer.
	5. Enter Member transfer from information (Agency, provider ID, Email contact, telephone, last service date, current waiver type, member street address and phone information)
	6. Enter Member transfer to information (Agency, provider ID, Email contact, telephone, new waiver type, member address and phone number information)

*Distribution:* The original form accompanies the original client case record to the receiving agency. A copy is filed in the duplicate case record maintained at the transferring agency.

#