



# 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 **receiving** agency \_\_\_\_/\_\_\_\_/\_\_\_\_.

Date ending authorization sent to the **originating** agency \_\_\_\_/\_\_\_\_/\_\_\_\_.