Attachment A

CENTRAL RECORD TRANSFER FORM

Consumer's (Legal) Name: ____

SS#_________________________________D.O.B.__________________________

(New) Address: ____

____
(city) (state) (zip)

Reason For Transfer:____

Comments: ____

Transferred Record From: Area or Agency______________________________

Name of person transferring record:____________________________________

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Area to Receive Record for Transfer: __________________________________

Transfer to: (Name & Address) ____

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____

Transferred Record Received By: Area or Agency:_________________________

Name of person Receiving record:_______________________________________

X____
Signature Date

PLEASE SEND SIGNED COPY OF THIS FORM TO:

NAME : ____

AREA : ____

ADDRESS: ____

To be completed for waiver participants:

Please check as completed:			
	Current Support Plan.		Current Information Sheet.
	Current Medicaid Eligibility Worksheet.		Current Case Notes.
	Current Cost Plan.		ABC updated.
	All documents filed in central record.		Current ICG.