Aged and Disabled Waiver Program Member Request to Transfer

treet Address: State: State: Date of Birth: ledicaid Number: Service Level: Phone Number: Phone Number: Phone Number: Service Level: Phone Number: If Qurrent Providers Are: State: Service Level: Service Level: Phone Number: State: Service Level: Phone Number: State: Service Level: Service Level: Service Level: Service Preferences:	IEMBER INFORM	MATION:							
ity:	ist Name:			First Name	First Name:				
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gal Representative (if applicable):	none Number:			Date of Bi	Date of Birth:				
Current Providers Are:	edicaid Number:			Service Le	Service Level:				
If you are receiving services from my current Case Management Agency I wish to transfer from my current Homemaker/Personal Assistant Agency I wish to transfer from a Traditional Agency to Personal Options If you are receiving services through Personal Options and wish to transfer to a Traditional Agency, please mark the option below: I wish to transfer from Personal Options to a Traditional Agency Wednesday Thursday Friday Saturday Sunda Friday Saturday Sunda Sunda Friday Saturday Sunda Sunda Friday Saturday Sund	gal Representative (if applicable):				Phone Number:				
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Monday Tuesday Wednesday Thursday Friday Saturday Sunda	omemaker Agency	<i>"</i> :							
If you are receiving services from a Traditional Model Agency, mark one of the three options listed below: I wish to transfer from my current Case Management Agency I wish to transfer from my current Homemaker/Personal Assistant Agency I wish to transfer from a Traditional Agency to Personal Options If you are receiving services through Personal Options and wish to transfer to a Traditional Agency, please mark the option below: I wish to transfer from Personal Options to a Traditional Agency Want to transfer because I want to transfer because		-							
If you are receiving services from a Traditional Model Agency, mark one of the three options listed below: I wish to transfer from my current Case Management Agency I wish to transfer from my current Homemaker/Personal Assistant Agency I wish to transfer from a Traditional Agency to Personal Options If you are receiving services through Personal Options and wish to transfer to a Traditional Agency, please mark the option below: I wish to transfer from Personal Options to a Traditional Agency I want to transfer because I want to transfer because		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
Traditional Agency, please mark the option below: ☐ I wish to transfer from Personal Options to a Traditional Agency Want to transfer because	□ I wish □ I wish	n to transfer from n to transfer from	m my currer	nt Homemaker/	Personal Ass	istant Age	ency		
	Traditional .	Agency, please	mark the	option below:			er to a		
Member/Legal Representative Signature Date	I want to transfer b	pecause							
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Member/Legal Representative Signature Date									
	Member/Legal Rep	presentative Sig	gnature				Date		
If an Agency/Provider is submitting this Transfer Request, it must be attached to the	If an Agency/Provi	idar is submittin	a this Trans	for Roquest its	must he attac	hed to the	۵		

member's record in CareConnection©. If a Member is submitting this Transfer Request, he/she may either mail it to: Bureau of Senior Services, 1900 Kanawha Blvd., East, Charleston, WV 25305, or Fax: 304-558-6647