

Aged and Disabled Waiver Program Participant Request to Transfer

PARTICIPANT INFORMATION:

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone Number: _____ Date of Birth: _____

Medicaid Number: _____ Service Level: _____

Legal Representative (if applicable): _____ Phone Number: _____

My Current Providers Are:
Case Management Agency: _____

Personal Attendant Agency: _____

Service Preferences:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours per day:							

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 Personal Attendant 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 _____

ADW Participant/Legal Representative Signature

Date

If an Agency/Provider is submitting this Transfer Request, it must be attached to the person's record in CareConnection®. If an ADW Participant 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