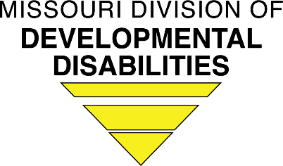
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DD Health Home Team

Transfer Form

The DD Health Home (DD HH) Transfer Form must be completed in full. Please complete the form, save a copy, and submit the form as an attachment using the **State of Missouri's Proofpoint system**. Include "DD HH Transfer" in the subject line (do not include additional information, especially PHI) and send to the DD Program Manager/DD HH Enrollment Coordinator at [DDHHEnrollTransferDischarge@dmh.mo.gov](mailto:DDHHEnrollTransferDischarge@dmh.mo.gov).

Any forms received after the 25th of the month are not guaranteed to be processed until the next month. This form is only applicable for transfers between DD HHs, and should only be used after both HHs agree to the transfer. If participant is transferring to a CMHC Healthcare Home or Primary Care Health Home, then a Discharge Form must be completed.

**Part 1**

DD HH Provider:       DD HH Medicaid Provider #:

**Receiving** DD HH Provider:       Last 4 Medicaid Provider #:

Has the receiving DD HH agreed to the transfer request?  Yes  No

Contact person at **receiving** DD HH who agreed to transfer:

Contact person at DD HH who **requested** transfer:

Date of Transfer of Services:

**Part 2**

Date:       MO HealthNet ID/DCN #:       Date of Birth:

Participant Name:

**Part 3**

Please select reason of transfer:

CH – Participant or guardian request for transfer

CM – Participant moved

CP – DD HH request for transfer (if different from reasons listed above):

CO – Other reason for transfer (if different from reasons listed above):

**Part 4**

**Please check and complete all eligibility criteria met:**

1. Chronic condition of Intellectual and/or Developmental Disability

2. Have or at risk of developing one of the following conditions:

Asthma

Dementia

Diabetes

Diagnosis of Autism Spectrum Disorder

Dependent on a Ventilator

Cardiovascular disease or hypertension

Chronic Obstructive Pulmonary Disease (COPD)

HRST Level of 3 or greater

Overweight (BMI>25)

Tobacco use

One of the Fatal Five Plus Conditions:

Bowel Obstruction

Dehydration

Gastroesophageal Reflux Disease (GERD)

Pulmonary Aspiration

Seizures

Sepsis

**Part 5**

**MO HealthNet/DMH USE ONLY:**

Effective Date of DD HH PMPM:       \*For **receiving** DD HH

Request Processed By       Date Form Received