Transfer Form

The CMHC Healthcare Home Transfer Form must be completed in full. Please complete the complete the form, save a copy, and submit the form as an attachment in an encrypted email or submit the **password protected** form to CMHCHCH@dmh.mo.gov. Indicate "CMHC HCH TRANSFER" in the subject line of the email.

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 CMHC HCHs, and should only be used after both HCHs have agreed to the transfer. If participant is transferring to a Primary Care Health Home, then a Discharge Form must be completed.

PART 1

Healthcare Home: _____ Medicaid Provider #: _____

Receiving Healthcare Home: _____

Has the receiving HCH agreed to the transfer request? ☐ Yes ☐ No

Contact person at **receiving** HCH who agreed to transfer: _____

Contact person at HCH who **requested** transfer: _____

Date of Transfer of Services: _____

PART 2

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

Participant Name: _____
First MI Last

Mailing Address: _____
Street

_____
City State Zip Code

PART 3

Does the participant have a Guardian/Parent? ☐ Yes ☐ No

If yes, Name of Guardian/Parent: _____
First MI Last

Guardian/Parent Address: (if different from participant) _____
Street

_____
City State Zip Code

Has the Guardian/Parent agreed to the transfer request? ☐ Yes ☐ No

PART 4

Please select reason of transfer:

☐ CH – Participant or guardian request for transfer

☐ CM – Participant moved

☐ CP – Healthcare Home request for transfer (if different from reasons listed above):

_____

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

_____

MO HealthNet/DMH USE ONLY:

Effective Date of HCH PMPM: _____ *For **receiving** HCH

Request Processed by: _____ Date Form Received: _____