

 **STATE OF MISSOURI**

 **DMH – DIVISION OF DD – REGIONAL OFFICES**

 **TRANSFER FORM**

**Transfer Requested:** Click or tap to enter a date.

**Transfer Type:** [ ] Services

 [ ]  Case Management Only

 [ ]  Non-Residential

 [ ]  Residential

 [ ]  Informational Specialist

**Name**:       **DMH ID Number:** **Date of Birth:**

**Medicaid Number:****Principle Diagnosis w/ code:** **ISP date:**

**Individual’s New Address** (Include City, State, Zip Code)**:****Telephone Number** (include area code)**:**

**Guardian Commitment:** Choose an item. **Contact Relationship:** Choose an item.

**Contact Person:** **Address** (Include City/ State/ Zip Code/ Phone Number)**:**

**Transferring From** [ ]  **Ended Authorizations** [ ]  **RO FTP#**

**County:** **TCM:** **Regional Office:** Choose an item.

**Transferring To** [ ] **Yes** [ ] **No Does a Regional Office Payee need notified/assigned?**

[ ] **Yes** [ ] **No Does a Regional RN need notified/assigned?**

**County:** **TCM:** **County FTP#       Regional Office:** Choose an item. **RO FTP#**

**Services Needed:** **Funding Source:** Choose an item. **If Other or Multiple Please List:**

 **Medicaid Waiver Slot #:**

**Does individual need on the Waiting List:** Choose an item.

**Placement Agency Name:**

**Brief Update** (ie. Reason for moving, concerns/issues receiving area should know about):

**File Audit Checklist:**

[ ]  Admission Documents [ ]  Waiver Choice Statement

[ ]  Legal Documents [ ]  Provider Choice Statements

[ ]  Diagnosis Information (including ICD-0 codes and collateral) [ ]  Budgetary Documents (approved UR/ISL budgets given to new TCM to enter for billing)

[ ]  All available Assessments (including MOCABI/Vineland) [ ]  PON and UR Recommendation form

[ ]  Current Individual Support Plan [ ]  Last 6 months of monthly/quarterly reviews

**File Audit Completed by:** **Date File Audit Completed:****Date Authorization was closed**

**Team requests transfer Meeting?** [ ]  Yes [ ]  No **Transition Meeting Date:** **Transfer Acceptance Date:**

**Authorization of Transfer**

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Sending TCM Signature Receiving TCM Signature

**Agreed Transfer Acceptance Date**: **Click or tap to enter a date.**

*For questions, concerns, or guidance please contact send email to* *transfers@dmh.mo.gov* *or* *transitions@dmh.mo.gov*

*Once the transfer/transition is agreed upon, submit completed form to Regional Office Contacts on Contact Brochure*