



State of Alaska • Department of Health and Social Services

Senior and Disabilities Services

Personal Care Services and Community First Choice-Personal Care Services

Notification of Transfer Form

Complete all of the information requested, print the form, record original signatures, and upload to a Change of Status note in Harmony.

Care Coordinators e- mail to: dsds.nflocwaiver@hss.soa.directak.net

Recipient Name: _____

Medicaid Number: _____

Agency Transfer OR Model Type Transfer

Current PCS Agency: _____

New PCS Agency: _____

Medicaid Provider #: _____

Medicaid Provider # _____

CFC Modifier SE None

PCS Modifier U3 None

Effective Date of Transfer (Date of New Agency or Model Type) _____

The above named "Current PCS Agency" will provide the "New PCS Agency" with copies of the contents of the recipient's file, in accordance with the "Authorization for Release of Information" form. The "New PCS Agency" must submit a completed transfer form to SDS within 10 calendar days of receipt of the recipient's information. If the Consumer is enrolled in the CFC Program; The Care Coordinator becomes responsible for the submission. The Care Coordinator must submit a complete transfer form to SDS within 10 calendar days of receipt of the recipient's information.

NAMES/SIGNATURES

Print Client's Name or Legal Representative if applicable: _____

Date: _____

Signature Client or Legal Representative

Print Name of "Current PCS Agency" Representative: _____

Date: _____

Signature of "Current PCS Agency" Representative

Print Name of "New PCS Agency" Representative: _____

Date: _____

Signature of "New PCS Agency" Representative

Print Name of Care Coordinator: _____

Date: _____

Signature of Care Coordinator