State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Personal Care Assistance Program

Notification of Transfer Form

Complete all of the information requested, print the form, record original signatures and scan and e-mail to: dsds.pcamailbox@direct.dhss.akhie.com, or fax to DSDS PCA Program at 907-269-8164

Recipient Name: ______________________________ Medicaid Number:__________________

☐ Agency Transfer *OR* ☐ Model Type Transfer

Current PCA Agency: ___________________________________ New PCA Agency: ____

Medicaid Provider #:_____________________ Medicaid Provider #:_____________________

Modifier ☐ U3 ☐ None Modifier ☐ U3 ☐ None

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

The above named "Current PCA Agency" will provide the "New PCA Agency" with copies of the contents of the recipient's file, in accordance with the "Authorization for Release of Information" form. The "New PCA Agency" must submit a completed 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 PCA Agency" Representative____

____ Date:________________________
Signature of "Current PCA Agency" Representative

Print Name of "New PCA Agency" Representative____

____ Date:________________________
Signature of "New PCA Agency" Representative