



State of Alaska • Department of Health and Social Services Senior and Disabilities Services
Personal Care Services and Community First Choice-Personal Care Services

PCA-16/CFC-03 Notification of Transfer Form

Complete all of the information requested, obtain signatures and upload to a Inquiry in Harmony.

Recipient Name: _____ Medicaid Number: _____

Agency Transfer

OR

Model Type Transfer

Current PCS Agency: _____

New PCS Agency: _____

Medicaid Provider #: _____

Medicaid Provider #: _____

PCA Modifier: Consumer Directed

Agency Based

CFC Modifier: Consumer Directed

Agency Based

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

May be no earlier than 15 days before the dates on the signature dates below

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 15 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:

Signature of Care Coordinator

Date: