Government of the District of Columbia
Department of Health Care Finance
Office of Disabilities and Aging
Elderly and Individuals with Physical Disabilities (EPD) Waiver

INTER-AGENCY TRANSFER FORM

(Transfer from one Case Management provider to another Case Management provider)

Beneficiary Name: ______________________________
Address: ______________________________
Telephone Number: ______________________________
Medicaid No.: ______________________________
Date of Birth: ______________________________

Discharging Case Management Provider: ______________________________
Discharging Case Manager: ______________________________
Recertification Date: ______________________________

DISCHARGING AGENCY: ______________________________
LAST DAY OF SERVICE: ______________________________

Waiver Services	Frequency	Cost	Provider

RECEIVING AGENCY: ______________________________
FIRST DAY OF SERVICE(s): ______________________________

Waiver Services	Frequency	Cost	Provider

REASON FOR TRANSFER:

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**Recertification Date= Date beneficiary's Medicaid expires*

All aspects of transfer including last and first date of services should be coordinated between and mutually agreed upon by the discharging and receiving agencies.

Changes to direct care services are not permitted during the inter-agency transfer process.

Case Manager Signature: ______________________ Date: ______________

Receiving Case Manager Signature
or Authorized Agency Representative: ______________________ Date: ______________