APPENDIX X SOURCE's

Rev. 01/16 UNIVERSAL Member WAIVER TRANSFER FORM (Non-Electronic)
For Georgia Medicaid

SOURCE Program Member's:

1. LOC Authorization Number: _____ Expiration Date: _____

2. Member Name

_____ DOB: _____
(Last, First, M.I.)

Soc. Sec. No. _____ Medicaid# _____

3. Other Contact Information: _____

4. **Member transfer from (Agency A) Information:**

Agency Name: _____ Provider ID# _____

County _____

Care coordinator/ CM / Contact person _____

Email _____ Telephone ( ) _____

Current Waiver type (CCSP/SOURCE/NOW-COMP/ICWP/GAPP) Last service date _____

Member's address _____

County _____ State _____ Zip _____

5. **Member transfer to (Agency B) Information**

Agency Name: _____ Provider ID# _____

County _____

Care coordinator/ CM / Contact person _____

Email _____ Telephone ( ) _____

Waiver type (CCSP/SOURCE/NOW-COMP/ICWP/GAPP) (circle) _____

Member's address _____

County _____ State _____ Zip _____

Telephone ( ) _____