cid:image001.jpg@01D0B724.EBF48280

**PMF 4.2.1 OUTGOING TRANSFER REQUEST:**  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Our agency has received a request from the member for a Plan Transfer:

Member’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CIS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New County of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Health Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Receiving Health Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Agency/City) (Case Manager Name/Phone)

Is participant on Methadone? YES \_\_\_\_\_\_ NO\_\_\_\_\_\_ Is participant on injection? YES \_\_\_\_\_\_ NO\_\_\_\_\_\_

**State the following if applicable; High Needs Services received, special needs, primary language, legal guardian name, DCSFS CM name/phone, County of DCSFS court of jurisdiction:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the member is on medications, explain why the member **has not** received a 30 day supply of medication/s:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*CENPATICO INTAKE PROVIDER\*\***

**DO NOT CLOSE THIS MEMBER UNTIL YOU HAVE BEEN DIRECTED BY THE CENPATICO TRANSITION COORDINATOR**

Please mark forms included in the transfer packet & indicate why form is missing:

\_\_\_\_Updated Face Sheet

\_\_\_\_Consent to Release Information

\_\_\_\_Medication Sheet

\_\_\_\_Nursing Notes & CM Progress Notes (last 3 months)

\_\_\_\_Psychiatric Progress Notes (last 3 months)

\_\_\_\_Psychosocial/ADHS-DBHS Annual Update

\_\_\_\_Psychiatric Evaluation

\_\_\_\_Intake Assessment/ADHS-DBHS General Assessment-Applicable Addendum

\_\_\_\_834 EA 1011 and EA1013/Demographics

\_\_\_\_Current ISP/Treatment Plan

\_\_\_\_SMI Determination Addenda (if applicable) \*If SMI form is missing from the file, follow “SMI verification” form process\*

\_\_\_\_COT Paperwork (if applicable)

\_\_\_\_ETI Form (if applicable)

Please “fax” or “secure email” the Member Transfer packet to:

Attn: Member Transition Coordinators

Fax: (844)683-1083

Email: [CAZmembertransfers@cenpatico.com](mailto:CAZmembertransfers@cenpatico.com)

For immediate or emergent related issues you can call: (866) 495-6738

Corina Ogaz Ext. 26189

Luis Villarreal Ext. 84522

Brian Laughlin Ext. 84504