

**WEST VIRGINIA I/DD WAIVER  
TRANSFER/DISCHARGE**

Must be received by the UMC **within seven calendar (7) days** of the transfer/discharge. Fax to (866) 521-6882 or email to [WVIDDwaiver@kepro.com](mailto:WVIDDwaiver@kepro.com).

<b>Name of Person Who Receives Services</b>		<b>Date</b>	
<b>SC Agency</b>		<b>Record #</b>	

**Transfer: From one Service Coordination agency to another.**  
An overlap of Service Coordination (up to 30-days) may occur for active participants.

<b>Transfer From (Agency)</b>		<b>Final Access Date</b> (last date of service provision for Transfer From agency-n/a if on the Wait List)	
<b>Transfer To (Agency)</b>		<b>Effective Date of Transfer</b>	

<b>Reason For Transfer (✓)</b>	<input type="checkbox"/>	Participant requests new SC provider
	<input type="checkbox"/>	Participant moved to a new geographic location
	<input type="checkbox"/>	Provider no longer offers Service Coordination
	<input type="checkbox"/>	Provider initiated transfer

**Additional comments:**

**Discharge: Permanently exiting the program**

<b>Effective Date of Discharge</b>		<b>Final Access Date</b> (last date of service provision-n/a if on the Wait List)	
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Please check (✓) if discharge refers to:  Active Participant  Participant on Wait List

<b>Reason for Discharge (✓)</b>	<input type="checkbox"/>	No longer a WV resident
	<input type="checkbox"/>	Deceased
	<input type="checkbox"/>	No longer eligible for I/DD Waiver
	<input type="checkbox"/>	Voluntarily declines the I/DD Waiver program
	<input type="checkbox"/>	Has not accessed direct support services in 30 days
	<input type="checkbox"/>	Discharge to Facility <b>Select Type of Facility</b>
		<input type="checkbox"/> Hospital <input type="checkbox"/> ICF/IID <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Psychiatric Facility <input type="checkbox"/> Rehabilitation Facility <input type="checkbox"/> Other Facility (Please Describe) _____

**Additional Comments:**

<b>Signature of Person Completing this Form</b>		<b>Date</b>	
<b>Signature of Person Who Receives Services</b>		<b>Date</b>	
<b>Legal Representative Signature</b>		<b>Date</b>	
<b>Witness Signature</b>		<b>Date</b>	