WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER
TRANSFER/DISCHARGE

Must be received by the MCO **within seven calendar (7) days** of the transfer/discharge.

Name of Member		**Date**	
Wraparound Facilitation Agency		**Medicaid ID**	

Transfer: From One Agency to Another
An overlap of Wraparound Facilitation (up to 30-days) may occur for active participants.

Transfer From (Agency) ☐ **BBH/BSS Interim Services** ☐ **CSEDW Services**		☐ **Final Access/Billing Date** (last date of service provision for Transfer From agency-n/a if on the Wait List)	
Transfer To (Agency) ☐ **CSEDW Services**		☐ **Start Date of Transfer for Services/Billing**	

Reason for Transfer (✓)	☐	Participant requests new service provider
	☐	Participant moved to a new geographic location
	☐	Provider no longer offers service
	☐	Provider initiated transfer
	☐	Participant is eligible for CSEDW Services

Additional Comments:

Discharge: Exiting the Program

Effective Date of Discharge		**Final Access Date** (last date of service provision-n/a if on the Wait List)	

Please check **(✓)** if discharge refers to: ☐ Active Participant ☐ On Managed Enrollment List

Reason for Discharge (✓)	☐	No longer a WV resident
	☐	Unable to reach or obtain FOC
	☐	Successfully Completed CSED Waiver
	☐	Voluntarily declines the CSED Waiver ☐ ACT instead of CSED ☐ PRTF instead of CSED
	☐	Has not accessed services in 365 days
	☐	Has not accessed at least one service in 30 days

Additional Comments:

Signature of Person Completing this Form		**Date**	
Signature of Person Who Receives Services		**Date**	
Legal Representative Signature		**Date**	
Witness Signature		**Date**	

Copy: ABHWVCSED@AETNA.COM