

**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@acentra.com.

Name of Person Who Receives Services		Date	
CM Agency		Record #	

Transfer: From one Case Management agency to another.

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

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

Additional comments:

Discharge: Permanently 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 Participant on Wait List

Reason for Discharge (✓)	<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 Select Type of Facility <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:

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