Traumatic Brain Injury (TBI) Waiver Program
Member Request to Transfer

MEMBER INFORMATION

Last Name: _____ First Name: _____ Middle Initial_____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Date of Birth: ____/____/_____ Medicaid Number _ _ _ _ _ _ _ _ _ _ _ _

Phone Number: (_____) __ __ __-__ __ __ __

Legal Representative: _____
(if applicable)

Phone Number: (____) __ __ __-__ __ __ __ (____)__ __ __ - __ __ __ __
Home cell

Personal Attendant Services Preferences

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours per day:							

TRADITIONAL AGENCY TRANSFER
I wish to transfer from my current provider: Case Management Agency-(Name)_____ Personal Attendant Service Agency-(Name)_____
PERSONAL OPTIONS TRANSFER
I wish to transfer **from Personal Options** to a Traditional Agency Model ☐ I wish to transfer **from the Traditional Agency** Model to Personal Options ☐

I want to transfer because _____

I understand that I will be contacted by Kepro, to explain the transfer process and my freedom of choice options

_____ _____
Member /Legal Representative Signature Date

Fax Form To:
Acentra Health
866-607-9903