PERSONAL CARE SERVICES PROGRAM
REQUEST TO TRANSFER

MEMBER INFORMATION:

Last Name:_________________________________ First Name:_______________________________________

Street Address:____

City:___________________________ State:_______ Zip Code:_______________ County:__________________

Phone Number:________________________________ Date of Birth:_____________________________

Medicaid Number:___________________________ Service Level(check one): _______ 1________ 2

Legal Representative (if applicable):______________________ Phone Number:________________________

My Current Agency is:____

I would like to transfer to: ____

Reason for transfer request: ____

____

____

Service Preferences:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours per day:							

____ __________________

PC Member/Legal Representative Signature Date

If an Agency/Provider is submitting this Transfer Request, it must be attached to the Member's record in PC Web portal. If a PC Member is submitting this Transfer Request, he/she may either mail it to: Bureau of Senior Services, 1900 Kanawha Blvd., East, Charleston, WV 25305, or Fax: 304-558-6647