Aged and Disabled Waiver Program
Participant Request to Transfer

PARTICIPANT INFORMATION:

Last Name:_____ First Name:_____

Street Address:_____

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

Phone Number:_____ Date of Birth:_____

Medicaid Number:_____ Service Level:_____

Legal Representative (if applicable):_____ Phone Number:_____

My Current Providers Are:
Case Management Agency:_____

Personal Attendant Agency:_____

Service Preferences:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours per day:							

If you are receiving services from a Traditional Model Agency, mark one of the three options listed below:

- ☐ I wish to transfer from my current Case Management Agency
- ☐ I wish to transfer from my current Personal Attendant Agency
- ☐ I wish to transfer from a Traditional Agency to Personal Options

If you are receiving services through Personal Options and wish to transfer to a Traditional Agency, please mark the option below:

- ☐ I wish to transfer from Personal Options to a Traditional Agency

I want to transfer because_____

_____

_____ _____

ADW Participant/Legal Representative Signature Date

If an Agency/Provider is submitting this Transfer Request, it must be attached to the person's record in CareConnection©. If an ADW Participant 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