

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: _____

Phone Number: (____) _____ - _____ (if applicable)
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:
Kepro
866-607-990

