TRAUMATIC BRAIN INJURY (TBI) WAIVER PROGRAM
MEMBER REQUEST TO TRANSFER

MEMBER INFORMATION:

Last_____ First _____ Middle Initial _____

Street Address _____

City _____ State_____ Zip Code _____ County _____

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

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

Legal Representative _____
(If applicable)

Phone Number: ( ) __ __ __-__ __ __ __ ( ) __ __ __-__ __ __ __
Home Cell

My Current Providers are:

Case Management Agency _____

Personal Attendant Services _____

Service 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
- ☐ Personal Attendant Service Agency

☐ 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 APS Healthcare, Inc. to explain the transfer process and my freedom of choice options.

_____ _____
Member/Legal Representative Signature Date

Fax Form To:
APS Healthcare, Inc.
1.866.607.9903