**Harvey-Marion County CDDO TCM Transfer Checklist and Cover Sheet**

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| **Consumer:** |  |
| **Current TCM Provider:** |  |
| **New TCM Provider:** |  |
| **Deliver to CDDO Date:** |  |

***List of Items to send with each transfer:***

Yes No N/A

[ ]  [ ]  [ ]  Current PCSP and Addendums (completed within the last year)

[ ]  [ ]  [ ]  Current Behavior Support Plan (if applicable)

[ ]  [ ]  [ ]  Current Psychotropic Medication Plan (if applicable)

[ ]  [ ]  [ ]  Risk Assessments (if applicable)

[ ]  [ ]  [ ]  Current IEP (If Applicable)

[ ]  [ ]  [ ]  Current Functional Assessment and Tier Score

[ ]  [ ]  [ ]  All Functional Assessment behavior data since the last Assessment

[ ]  [ ]  [ ]  Current Plan of Care (if applicable)

[ ]  [ ]  [ ]  3160 and/or Current 3161

[ ]  [ ]  [ ]  Current Needs Assessment and MR-10 (SHC Schedule) \*if applicable\*

[ ]  [ ]  [ ]  Current MR-1

[ ]  [ ]  [ ]  Current MR-4 and/or MR-5

[ ]  [ ]  [ ]  Current Physical or Health Assessment (completed within 2 years)

[ ]  [ ]  [ ]  Psychological Evaluation

[ ]  [ ]  [ ]  Initial HMCDDO Records (application, eligibility, releases, TCM/Provider Choice forms)

[ ]  [ ]  [ ]  Copy of Social Security Card

[ ]  [ ]  [ ]  Copy of Medicaid Card and/or other insurance

[ ]  [ ]  [ ]  Copy of Birth Certificate

Yes No N/A

[ ]  [ ]  [ ]  Copy of Kansas ID or other form of ID

[ ]  [ ]  [ ]  Port/Transfer Papers (if applicable)

[ ]  [ ]  [ ]  Copy of Guardianship Papers (if applicable)

[ ]  [ ]  [ ]  Current List of Medications (if applicable)

[ ]  [ ]  [ ]  Any Legal Papers (Probation, Protection from Abuse, Court orders, CINC Petitions, etc.)

[ ]  [ ]  [ ]  Cab Card or application/approval letters (if applicable)

[ ]  [ ]  [ ]  Funding Award Letters/Funding Requests

[ ]  [ ]  [ ]  Accident/Incident/Seizure Reports (if applicable) (past year)

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***Please note here why documents were not sent and anything else new provider needs to know***

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***TCM Provider Transition Form:***

*Instructions: In the case of a person transitioning services, the current provider will* ***always*** *complete this form and send it to the new TCM provider.*

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| --- | --- |
| **Medicaid #:** |  |
| **Current TCM Provider** | **New TCM Provider** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency Name:** |  | **Agency Name:** |  |
| **TCM KMAP #:** |  | **TCM KMAP #:** |  |
| **TCM Units Billed (or will be):** |  | **Start Date:** |  |
| **Last Date of Service:** |  |  |  |