|  |  |
| --- | --- |
| Child Name: | |
| ITOTS Number: | DOB: \_\_\_ / \_\_\_ / \_\_\_ |
| Name of Transferring/Sending SC: | SC Phone Number: |
| Transferring *from* ITC of: | |
| Transferring *to* ITC of: | |
| **TRANSFER DATE:** \_\_\_ / \_\_\_ / \_\_\_  \*For children with Medicaid: Sending system will bill EI TCM if transfer occurs on or after the 15th of the month. If transfer occurs before the 15th, and the sending system had a billable contact, the sending system *may choose to* contact the receiving system at the end of the month to determine if the receiving system made a billable contact and will bill for EI TCM. | |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** | **NO** | **N/A** | **DESCRIPTION** |
|  |  |  | Current IFSP with the addendum; all reviews, and the transition pages completed according to child’s age. (Include cell phone number and/or new address and phone number) |
|  |  |  | Eligibility Determination |
|  |  |  | Physician Certification (for all current IFSP services) |
|  |  |  | Most Recent Health Status Indicator Form |
|  |  |  | Financial Information:   * Family Cost Share Agreement * Copy of Insurance Card / Insurance Information with Appeal (if applicable) * Notice to DMAS - Family Declining to Bill Private Insurance (if applicable) |
|  |  |  | Does Current Provider (or providers) Serve the Receiving System? |
|  |  |  | Is Interpretation Needed?  If yes, What Language(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **Additional Information:** |