State of Alaska • Department of Health • Senior and Disabilities Services Division
and Community First Choice-Personal Care Services

PCS-16/CFC-03 Notification of Transfer Form

Complete all of the information requested, obtain signatures, and upload to a Inquiry in Harmony.

Recipient Name: _____ Medicaid Number: _____

Agency Transfer ○ *OR* Model Type Transfer ○

Current PCS Agency: _____ New PCS Agency: _____

Medicaid Provider #: _____ Medicaid Provider #: _____

PCA Modifier: Consumer Directed ○ Agency Based ○

CFC Modifier Consumer Directed ○ Agency Based ○

Effective Date of Transfer (Date of New Agency or Model Type) _____
May be no earlier than 15 days before the dates on the signature dates below

The above named "Current PCS Agency" will provide the "New PCS Agency" with copies of the contents of the recipient's file, in accordance with the "Authorization for Release of Information" form. The "New PCS Agency" must submit a completed transfer form to SDS within 15 calendar days of receipt of the recipient's information.

NAMES/SIGNATURES

Print Client's Name or Legal Representative if applicable: _____

_____ Date: _____
Signature Client or Legal Representative

Print Name of "Current PCS Agency" Representative _____

_____ Date: _____
Signature of "Current PCS Agency" Representative

Print Name of "New PCS Agency" Representative _____

_____ Date: _____
Signature of "New PCS Agency" Representative

Print Name of Care Coordinator _____

_____ Date: _____
Signature of Care Coordinator