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| 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. |

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| **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)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Additional Information:** |