

**HCBS TRANSFER - CASE RECORD TRANSMITTAL COVER MEMO**

**TO:**

\_\_\_\_\_  
Name/Address of Receiving ICC Agency  
\_\_\_\_\_  
\_\_\_\_\_

**FROM:**

\_\_\_\_\_  
Name/Address Sending ICC Agency  
\_\_\_\_\_  
\_\_\_\_\_

**DATE:**

\_\_\_\_\_

**Re:** HCBS Transfer

Child's Name (LN, FN, MI): \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ MA ID#: \_\_\_\_\_

The above referenced child moved from \_\_\_\_\_ county to  
\_\_\_\_\_ county on \_\_\_\_\_. Enclosed is copy of our complete case  
file.

Following is the address for the former County Medicaid Office:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

cc: LGU (Sending County)  
OSU