## FIT Program Child/ Family Transfer

Date:			
Person Completing Form:		Role:	Phone:
Called and spoke to:			Phone:
Transf	erring From Agency:		
Agency	Transferring to/Receiving Agency: _		
$\Box$ I	Signed copy of parent/guardian Release Requesting a transfer from your agency Sending transfer to your agency		
Name o	of Child being transferred:		Child's DOB:
	Parent/Caregiver Name:		
	Address:		
	Phone Number:	Relationship to Child	d:
Remember on or before the 15th of the following the second	re the 15th of the month, then the new Family Service f the month in order to bill services for that month.	nth, the "original" Family Service Coording e Coordinator bills for the entire month. Pr the original agency to the re	one call):  nator is authorized to bill for that month. If the transfer occurs providers shall not postpone the transfer of a child until after ecceiving agency within 4 business days of
		completed since initial evaluation  e exact spelling of the child's name where the service providers (i.e. Medical documents and discuss information of the original agency and is	me on the Medicaid card, if possible) ical provider(s), CYFD caseworker, etc.)

Revision Date: 10/20/2021