*Program descriptions and eligibility requirements are available in the program policy manuals.*

**Instructions:**

1. The Support Coordinator completes this form and has the individual or legal guardian sign it. In place of signing, the individual/legal guardian may submit a written request for transfer that names the program the individual is requesting to transfer from and the program they are requesting to transfer to.
2. Upload the completed transfer request form in iRecord, together with the individual/legal guardian’s written transfer request if they provided one; then, notify DDD.SCHelpdesk@dhs.nj.gov using the subject line: **DDD ID#, Program Transfer**.
3. An individual can only be enrolled in Medicaid program at a time.

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| **General Information** |
| Individual’s Name: Enter text.DDD ID: Enter text.DOB: Enter text. | Is the individual receiving a DDD-funded service? Yes [ ]  No [ ] If yes, list the service(s): Enter text. |
| Support Coordination Agency Name: Enter text.Support Coordinator Name: Enter text. |
| **Program Transfer Requested**  |
| Transfer From: *(select one)*[ ]  Community Care Program (CCP)[ ]  Supports Program (SP)Is the individual receiving Private Duty Nursing (SP+PDN)? Yes[ ]  No[ ] [ ]  Managed Long Term Services & Supports (MLTSS) |
| Transfer To: *(select one)*[ ]  Community Care Program (CCP) *Enrollment occurs* ***only*** *through the Waiting List or an approved emergency.*[ ]  Supports Program (SP) Is the individual approved for Private Duty Nursing (SP+PDN)? Yes[ ]  No[ ] [ ]  Managed Long Term Services & Supports (MLTSS)[ ]  Admitted to a skilled nursing facility and approved for long-term care, or stay will exceed 180 days. |
|  | Admission Date: Enter text. | Facility Name: Enter text. |
|  | Address: Enter text. | Phone Number: Enter text. |
| **Reason for Request** |
| Please explain: Enter text. |

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| **Signature of Individual or Legal Guardian, if applicable** |
| Signature:  | Date:  |