# NEVADA HEALTH AUTHORITY

## NEVADA MEDICAID

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Joe Lombardo,
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# TRANSFER FORM FOR 1915(I) SERVICES

**Date of Request** _____

This form is to be completed when a recipient of 1915(i) services including Adult Day Health Care, Day Habilitation or Residential Habilitation is interested in transferring to another enrolled 1915(i) provider. This form must be completed in its entirety to be considered valid.

Form should be submitted via email to 1915i@nvha.nv.gov a minimum of **7 business days** prior to the requested transfer start date.

**SECTION I: RECIPIENT INFORMATION**

The Recipient or Authorized Representative (AR) on behalf of the Recipient must complete all sections and sign Section I.

| | | | |
|---|---|---|---|
| Last Name: | | First Name: | |
| Medicaid ID: | Date of Birth: | Phone: Number | |
| Change in condition: ☐ Yes or ☐ No | If yes, what has changed: | | |
| Reason for transfer: | | | |
| Name of Current Provider: | | End Date with Current Provider: | |

**Recipient/AR must initial each statement and sign below:**

☐ I understand that services will be terminated with my current 1915(i) provider, and I have notified my current provider of my last date of service with them.

☐ I understand that I can only receive services from one provider at a time.

☐ I have NOT been offered, nor have I received, any compensation or incentive to transfer.

☐ The recipient, or AR, attest that I have completed this form and understand the actions that will take place upon my signature.

| | | | |
|---|---|---|---|
| Recipient/AR *(print name)* | | | |
| Recipient/AR Signature | | Date | |

| | | | |
|---|---|---|---|
| New Provider Name | | | |
| New Provider NPI | | Requested Start Date | |

**The new 1915(i) provider must initial the following statements and sign below:**

☐ I have met with the recipient/AR and provided a copy of our policies/procedures.

☐ No information has been implied to the recipient that a failure to transfer will result in loss of Medicaid eligibility or that the former provider is unable to continue services.

☐ No compensation or incentive have been made, or offered, in relation to this transfer request.

☐ No assurances regarding an increase in hours have been made to the recipient.

| | | | |
|---|---|---|---|
| New Provider Signature | | Date | |