NOTIFICATION OF MEDI-CAL INTERCOUNTY TRANSFER

Instructions: Complete each space or box. If information does not pertain to this case, indicate with N/A.

Receiving county name and address	Sending county name and address

Case Name/Beneficiary Information

Case name		Phone number ( )	Alternate phone number ( )
Address (number, street)		City	ZIP code
Authorized representative (AR) ☐ Yes ☐ No	AR name	AR phone number ( )	Beneficiary's primary language

Receiving county follow-up on changes related to intercounty transfer

Name	Aid Code	Income/How Often Received	Share-of-Cost (SOC)

Other Case Information

☐ CE for: _____
☐ CEC for: _____
CEC period: _____
☐ TMC period: _____
☐ Annual redetermination due date: _____
☐ LTC period of ineligibility: _____
☐ Court case: _____
☐ Other: _____

Documents in Transfer Packet

☐ Statement of Facts and applicable supplements/MC 210 RV
☐ Social security card(s)
☐ Identifications
☐ Case narrative
☐ Budget work sheets for MFBU/MBU
☐ Computer generated case documents
☐ Last NOAs for share-of-cost
☐ Income verifications
☐ Other Health Coverage Information (DHCS 6155)
☐ Pregnancy verification for: _____
☐ Primary wage earner: _____
☐ MC 13s and Proof of Alien Status for: _____
_____
☐ Property verifications or MC 176 P
☐ Family Support Information (CW 2.1s)
☐ Authorized Representative Form/Letter
☐ SP-DDSD Decision/Incapacity Verification for: _____
_____
☐ Other(s) (list): _____

Sending County Worker Information

Worker name		Worker number	Date ICT packet sent
Phone number ( )	Fax number ( )	E-mail address	