

**HCBS Transfer -
Exceeding Capacity Turnaround Form**

Part 1 - Notification that County is Exceeding Capacity	
To: Joyce Billetts, Statewide Coordinator HCBS Waiver Division of Children and Families	Date: _____
From: _____ <div style="text-align: center; font-size: small; margin-top: 5px;">Name of Receiving ICC Agency</div>	_____ <div style="text-align: center; font-size: small; margin-top: 5px;">Supervisor's Name</div>
_____ <div style="text-align: center; font-size: small; margin-top: 5px;">Receiving County</div>	_____ <div style="text-align: center; font-size: small; margin-top: 5px;">Supervisor's Signature</div>
Re: Child's Name _____ Medicaid ID: _____ <div style="text-align: center; font-size: small; margin-top: 5px;">(Ln, FN, MI)</div>	
Sending ICC Agency: _____ Sending Co: _____	
Date of Transfer _____ Date Anticipate Return to Capacity _____	

Part 2 - Notification that County has Returned to Approved Capacity	
To: Joyce Billetts, Statewide Coordinator HCBS Waiver Division of Children and Families	Date: _____
From: _____ <div style="text-align: center; font-size: small; margin-top: 5px;">Name of Receiving ICC Agency</div>	_____ <div style="text-align: center; font-size: small; margin-top: 5px;">Supervisor's Name</div>
_____ <div style="text-align: center; font-size: small; margin-top: 5px;">Receiving County</div>	_____ <div style="text-align: center; font-size: small; margin-top: 5px;">Supervisor's Signature</div>
Date Program Returned to Approved Capacity: _____	
Total Number of Months Above Capacity: _____	