

**NYS Office of Mental Health
Home and Community Based Services (HCBS) Waiver for Children**

HCBS TRANSFER - NOTIFICATION OF TRANSFER

TO: Operations Support Unit - Waiver
Finance Group, First Floor
44 Holland Avenue
Albany, NY 12229

DATE: _____

FROM: _____
Name of Receiving ICC Agency

Name of ICC Supervisor (Print)

Signature of ICC Supervisor

Re: _____
Child's Name (LN, FN, MI)

Medicaid ID #

The above referenced child has transferred as follows:

1. **New ICC Agency/New Medicaid County (Situation #1)**

New ICC Provider Agency

Effective Date of Transfer

New Medicaid County

2. **New Medicaid County/ICC Agency Remains the Same (Situation #2)**

Existing ICC Provider Agency

Effective Date of Transfer

New Medicaid County

3. **New ICC Agency/Medicaid County Remains the Same (Situation #3)**

New ICC Provider Agency

Effective Date of Transfer

Existing Medicaid County

CC. Sending ICC Agency (Options 1 & 3 only)
Sending LDSS (Options 1 & 2 only) (For informational purposes only)
Receiving LGU (Option 1 & 2 only) (For informational purposes only)
Child/Family (All options)