Transfer Form

The Primary Care Health Home Transfer Form must be completed in full. Please complete the form, save a copy, and submit in a secure/encrypted email to PCHH@dss.mo.gov. Indicate "PCHH TRANSFER" and the number of forms attached in the **subject line** of the email.

This form is only applicable for transfers between PCHHs, and should only be used after both Health Homes have agreed to the transfer. If participant is transferring to a CMHC Health Home, then a Discharge Form must be completed.

PART 1

Date: _____

Current Health Home: _____ HH Last 4-digit Prov #: _____

Receiving Health Home: _____ HH Last 4-digit Provider #: _____

Contact person at current HH who agreed to transfer: _____

Contact person at receiving HH who requested transfer: _____

PART 2

Mo HealthNet ID/DCN#: _____ Date of Birth: _____

Participant Name: _____ _____ _____
Last Name First Name MI

PART 3

Please select reason for transfer:

_____ CH – Participant or guardian request for transfer

_____ CM – Participant moved

_____ CP – Health Home request for transfer (if different from reasons listed above):

_____

_____ CO – Other reason (if different from reasons above):

_____

PART 4

MO HEALTHNET USE ONLY:

Date Form Received: _____ Date Form Processed: _____

Discharge Date: _____ Start Date: _____

Processed by: _____