

# Transfer of Service Facilitation Summary

CCS Participant Name: \_\_\_\_\_ Date of Transfer Request: \_\_\_\_\_

DOB: \_\_\_\_\_ Is this the first transfer of this CCS Participant?    Yes    No

**Transfer Initiated By:**

- CCS Participant/Guardian
- CCS Service Facilitation Agency
- Other: \_\_\_\_\_

**Reason For Transfer:**

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**Status of CCS Paperwork:**

- Next Recovery Plan Due: \_\_\_\_\_
- Most Recent Assessment Update: \_\_\_\_\_
- Physician's Prescription Due: \_\_\_\_\_

Verified DCDHS
_____ Initials

**Important Providers/Supports (include contact information):**

- Psychiatrist: \_\_\_\_\_
- Primary Care Provider: \_\_\_\_\_
- Natural Support/Guardian: \_\_\_\_\_

**Upcoming Appointments (psychiatrist, PCP, therapist, etc.):**

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**Clinical Recommendations/Important Things to Know:**

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**Current (pre-transfer) Service Facilitator Contact Information:**

Service Facilitator Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

\_\_\_\_\_  
CCS Participant/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Current Service Facilitator Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Current Mental Health Professional Signature

\_\_\_\_\_  
Date

**STOP here and send to CCS Intake. Remainder of form to be completed by New SF Agency.**

**Case Transfer Consultation Between Old and New SF Agency**

**Date:** \_\_\_\_\_

**Notes:**

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\_\_\_\_\_  
New SF Agency MHP/SD Signature

\_\_\_\_\_  
Date

Tasks for new SF Agency to complete upon completion of transfer:

- Assign Service Facilitator
- End-date Recovery Plan service authorizations for former SF agency
- Authorize services for new SF agency (Assessment, Planning, Facilitation)
- Review Assessment for need to update
- Review Recovery Plan for need to update