# 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 |
|---|---|---|

MC 360 (06/07)