Community Supports (CS) Provider Reassignment Request

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This form must be completed by the new CS provider requesting that the member be reassigned to their agency. The form should be submitted along with the TAR 50-1 authorization request and a program referral.

MEMBER AND PROVIDER INFORMATION

Member Name: _____ Member CIN: _____

Date of Birth: _____ Member Phone Number: _____

REASSIGNMENT REASON (SELECT ONE)

◯ Member is requesting assignment to a new CS Provider

◯ Member moved and CS Provider does not serve that county

MEMBER CONSENT

Member agreed to reassignment: ◯ YES ◯ NO Date consent obtained: _____

Consent Obtained Via: ◯ Phone ◯ In Person ◯ Other: _____

_____ _____ _____

Form Completed by (Name) Signature Date

Please allow up to 14 days to process reassignment request.

Dates of service may be modified to prevent overlap with existing Services

Please submit through the Provider Portal as an attachment to the TAR 50-1 request, along with the program referral form.