



EPD WAIVER TRANSFER FORM
 Elderly and Physical Disabilities (EPD) Waiver
 Long Term Care Administration
 Department of Health Care Finance
 Government of the District of Columbia



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DISCHARGING PROVIDER					
#	Waiver Service(s)	Frequency	Cost	PA#	End of Care Date
	Provider Name:	Address: Á	Provider ID:	Phone:	Provider Email:
Notes:					
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	Provider Name:	Address: Á	Provider ID:	Phone:	Provider Email:
Notes:					
	Provider Name:	Address: Á	Provider ID:	Phone:	Provider Email:
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RECEIVING PROVIDER

- All aspects of transfer including last and first date of services should be coordinated between and mutually agreed upon the discharging and receiving agencies.
- Changes to direct care services are not permitted during the inter-agency transfer process.

