Transfer of Children's Services Act (CSA) Jurisdiction for Medicaid Funded Residential Placement

This form is to be completed by the Authorized CSA; once completed, please forward to Service Authorization Contractor.

Name of Youth: _____

Medicaid Number: _____

Residential Treatment Provider: _____

Provider Address: _____
Street

_____
City State ZIP

NPI: _____

Name of Locality: _____ **FIPS/CSA Locality Code:** _____

I certify the following:

This youth is no longer affiliated with _____ as of
Name and FIPS/CSA Code

_____ and is now affiliated with _____.
Date Name and FIPS/CSA Code

Authorized CSA Signature: _____

Print Name: _____

Title: _____

Date: _____