

Draft Transmittal Form

Date: XXXXXX

**(XXX) County Local Department of Social Services
or (Plan Name)**

Child's Name:

DOB:

CIN:

Worker:

Foster Parent/s Name:

Address:

Telephone:

This child is currently enrolled in (Name of Plan) and is entering into Foster Care.

Plan ID number: _____ Primary Care Physician:

This child is entering into/is currently in Foster Care and is being enrolled in (Name of Plan).

Effective Date of Enrollment: _____

This child is being disenrolled from (Name of Plan).

Plan ID number: _____ Primary Care Physician:

This child has moved to the following address:

Street:

City, State, Zip:

Telephone:

Other Action:

Name of Foster Care Coordinator Telephone Email

Name of MCO Liaison Telephone Email