

ICF/ID TRANSITION PROGRAM APPLICATION

Name of Individual: _____

ICF/ID Name: _____

Medicaid ID# (if known): _____

Person Completing Form: _____

Relationship to Individual: *(circle)* self family guardian
other _____

Contact Name for Follow-up: _____

You will receive a letter acknowledging receipt of your application, so please print clearly:

Contact Mailing Address: _____

Contact Phone Number: _____

I understand that by completing this form I am applying to be considered for the ICF/ID Transition Program.

Individual's Signature/Mark: _____

Please return this application to:
Utah Department of Health
Bureau of Authorization and Community Based Services
Attn: Glen Larsen
P.O. Box 143112
Salt Lake City, Utah 84114-3112
Phone: 801-538-9294

**ALL MAILED APPLICATIONS MUST BE POSTMARKED NO LATER THAN
September 25, 2015**

**FAXES MUST BE RECEIVED NO LATER THAN 5:00 PM ON
September 25, 2015
FAX: (801) 536-0494**

