**Alameda County Behavioral Health Care Services**

**Request for Inter-County Transfer Assistance**

By signing the attached form (MC-382), you are requesting to assign Alameda County Behavioral Health Care Services (ACBH) as your authorized representative to act on your behalf with the Alameda County Social Services Agency. As your authorized representative, you are requesting ACBH to transfer your currently active, out of county Medi-Cal to Alameda County.

By signing below, you are acknowledging the following:

* You are stating that you are currently an Alameda County resident and that you intend to continue to reside in Alameda County.
* You understand that your Medi-Cal coverage will be transferred to Alameda County which may impact your ability to receive services in another county.
* If you move out of Alameda County, you will need to contact the Alameda County Social Services Agency to request to that your benefits be transferred to your new county of residence. This process can take up to 45 days.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that I am requesting ACBH to act

(Print Name)

on my behalf to request an inter-county transfer of my Medi-Cal benefits.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Client Signature) (Date)