**ACBH Provider Relations ICT Request**

\*Please Fax the following information for **each** ICT request along with **signed MC382**

|  |  |
| --- | --- |
| **Requestor Information** | |
| Agency Name |  |
| Contact Person |  |
| Contact phone # **and** Fax # |  |
| Contact e-mail |  |
| Date Sending |  |

|  |  |
| --- | --- |
| **Client Information** | |
| Client Name |  |
| Client PSP # |  |
| Client SSN |  |
| Program Intake Date: |  |
| Client Resident Address (Alameda County) |  |
| * Homeless with Intent to reside in Alameda County | (Indicate city where homeless) |

**INTERNAL USE ONLY (to be completed by Provider Relations staff)**

|  |  |
| --- | --- |
| Date Received |  |
| HIT assigned |  |
| CalWin Case # |  |
| * ICT Sent to SSA (date) |  |
| Date Pending |  |
| * ICT completed (date) |  |

|  |  |
| --- | --- |
| **Reason for Return** | **Comments** |
| * Incomplete PR-ICT form |  |
| * Incomplete MC 382 |  |
| * SSI Medi-Cal (aid code 10,20,60) | Client must call Social Security directly to report address change |
| * Other |  |

**Fax completed forms to (510) 777-2226**

**PR-ICT**