BLAIR COUNTY DRUG and ALCOHOL PROGRAM, INC.
FUNDING TRANSFER

This form is to identify clients who are no longer eligible for Blair County funding due to having been deemed eligible for services through CCBHO:

Client Name: ____

Client Social Security #: ____

Client used ______ units out of _______ units requested for ___________________
(state level of care, with most recent authorization)

Date client became eligible to bill MA: ____________________________________
(System active date)

Counselor Name: ____

Date completed/faxed: ____

Fax to Donna Carter at: 814-381-0922