1301 International Pkwy.
Suite 400
Sunrise, FL 33323

SUNSHINE HEALTH CHILD WELFARE SPECIALTY PLAN

Transition Assistance Expanded Benefit Request Form

Date: _____

Name of Community Based Care (CBC)/Case Management Organization (CMO) staff person submitting form: _____

Name of CBC/CMO Agency: _____

Address of CBC/CMO: _____

Phone number of CBC/CMO: _____

Adult Member ONLY

Name of Adult Member: _____

Phone number: _____

Address: _____

*Note: Completion of a W-9 form is required by the adult member in order to process the transition assistance payment. Payment is made directly to the adult member.

Member Name: _____

Member Medicaid Number: _____ **Member DOB:** _____

1. Member is or has been residing in licensed out of home foster care for a minimum of six (6) months immediately prior to the member's 18th birthday (check one):
   ☐ **yes** or ☐ **no**. If no, please stop here. If yes, please complete the additional information below.

2. **List items/services being requested:**

_____

_____

3. **Please describe how this request supports the transitioning youth in establishing safe and stable housing.**

_____

_____

4. **Description of supporting documentation submitted** (appropriate supporting documentation MUST be attached in order to process).

_____

_____

Total transition assistance amount requested: $_____

- **Email form and supporting documentation to CWtransitions@centene.com**
- **The form and supporting documentation can be faxed to 1-855-478-2890**
- **The form and supporting documentation may be mailed to: Sunshine Health 1301 International Parkway, Suite 400, Sunrise, FL 33323. Attention: Child Welfare Specialty Plan Department**
- **Please send any questions via email to CWtransitions@centene.com.**

Sunshine Health Internal Use Only:

☐ Approved ☐ Partial Approval ☐Denied

Signature of Director of Operations, Child Welfare Programs:

_____

If partially approved or denied, reason: _____

Date of determination: _____

Signature of VP, Child Welfare Programs: _____