SELF-DETERMINATION DIS-ENROLLMENT FORM

Self-Determination in Long Term Care
DISENROLLMENT FORM

Name of Participant:_____

Medicaid #: _____**SS#**_____**DOB**_____

Date of enrollment/start of budget:_____

Name of Representative (If Necessary): _____

I, _____
am voluntarily/involuntarily terminating my participation in the Self-Determination in Long Term Care option. I understand that I will return to agency provided care management at this time, but if I decide I want to return to the Self-Determination option as a participant at any time, I may call 1-888-897-8050 and someone will revisit my home to discuss my re-enrollment.

_____ _____
Signature of Participant/Representative **Date**

To Be Completed by the Support Coordinator

Reason for Disenrollment: _____
_____

What problem solving measures have you taken to encourage continued participation?
_____
_____
_____

What referrals have been made to assure that personal care needs are met for this individual?
_____
_____

Adequate Action forms completed? YES_____ NO, Why_____

_____ _____
Support Coordinator Date