UPCAP SERVICES, INC

MI CHOICE WAIVER DISENROLLMENT NOTIFICATION

Waiver Agency Name (Select One):	UPCAP
Medicaid Provider ID Number:	7059424
Phone Number: ( ) -	Fax Number: ( ) -
Contact Person:	

Participant Information

First Name:			Last Name:	
Address (No. & St., Apt., etc.):			Check if address has changed: **Yes:** ☐ **No:** ☐	Medicaid ID Number:
City:	State:	ZIP:	Phone Number: ( ) -	

Disenrollment Information

MI Choice Stop/LOC 22 End Date: _____

Reason for Disenrollment: (Check Applicable Reason)				
☐ Death	Date of Death:			
☐ Nursing Home Placement	Date of Admission:			
☐ Nursing Home Information	Name:			
	Address (Number & St., Apt., etc.):	City:	State:	ZIP:
☐ No longer Eligible for MI Choice	Reason:			
☐ Enrolled in Home Help	Date of Enrollment:			
☐ Moved New Address:	Address (Number & St., Apt., etc.):	City:	State:	ZIP:
☐ Other (Explain):				

I certify that the information above is true, accurate, and complete to the best of my knowledge.

_____ _____

Signature of Supports Coordinator **Date**

UPCAP Staff Notified: _____

Date of Notification: _____

Method of Notification: ☐ Email ☐ Fax ☐ Other: _____