**Michigan Department of Community Health**

**MI CHOICE WAIVER DISENROLLMENT NOTIFICATION**

**INSTRUCTIONS**

This form must be used by MI Choice waiver agencies to notify local Michigan Department of Human Services (DHS) offices of MI Choice participant disenrollment dates, as well as subsequent changes made to MI Choice disenrollment dates.

**General Instructions**

* Waiver agencies must notify local DHS offices in writing within five business days of participant disenrollment from MI Choice. The MI Choice end date is the last day of the participant's enrollment in MI Choice.
* When the waiver agency needs to change a previously reported MI Choice disenrollment date, the waiver agency sends written updates to the local DHS office on a disenrollment form, with the new date and the reason for altering the original date.
* Waiver agencies retain the original enrollment forms in the participant’s record for a minimum of six years and send a copy of each form to DHS.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  **MI CHOICE WAIVER DISENROLLMENT NOTIFICATION** | |  |  | | --- | --- | | Waiver Agency Name (Select One):  UPCAP | | | Medicaid Provider ID Number:  7059424 | | | Phone Number:  (906) 632 - 9853 | Fax Number:  (906) 632 - 9840 | | Contact Person:  Ellen Grigsby, LLMSW | | |

**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 Waiver Agency Representative** |  | **Date** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| DHS County Office (Select One): |  | None Selected |  | District Number: |  |  |
| Date of DHS Office Notification: |  |  |  |  |  |  |

Method of DHS submission (check):  Email  Fax  Phone Call  Dropped off at DHS office

|  |  |  |
| --- | --- | --- |
| Other: |  |  |