Medicaid Home and Community Based Program
Special Circumstance Involuntary Disenrollment Notice of Intent

Program:

Program Contact Person: Phone:

Address:

Client Name: Phone:
Medicaid ID#:

Legal Guardian Name: (if applicable) Phone:

Client Address/Residence Type:

_____

Street Address Apt. # City, State, Zip Code

Current Residence Type (Circle):

Home Apartment Supervised Apartment

Assisted Living Nursing Facility ICF/MR

Date of Enrollment:	Date of Intended Disenrollment:

Special circumstance involuntary disenrollments:
Individual:

☐ no longer meets corresponding institutional level of care requirement: nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR)

☐ health and safety needs cannot be met by the current program's services and supports

☐ has demonstrated non-compliance with the agreed upon care plan/support plan and is unwilling to negotiate a plan of care that meets minimal safety standards

☐ poses an imminent danger to themselves or others

Summarize program interventions to rectify the identified problem, prior to the intended disenrollment decision: (submit corroborating documents)

Summarize Program discharge planning activities: (submit attachments as necessary)

Completed by:_____ Date:_____

Telephone number:_____