

Services My Way Disenrollment Form

Name of Participant: _____

Medicaid #: _____ SS#: _____ DOB: _____

Name of Representative (If Necessary): _____

For voluntary or involuntary termination of SMW, attach a revised service plan

Voluntary Termination of SMW

I, _____
am voluntarily discontinuing my participation in the Services My Way service model. I understand that I will return to traditional agency provided services at this time, but if I decide I want to return to Services My Way at any time, I may contact my Care Manager/Supports Coordinator to discuss my re-enrollment.

Participant Signature

Date

Representative Signature

Date

Care Manager/Supports Coordinator Signature

Date

Involuntary Termination of SMW

Reason for involuntary termination:

- Health and Safety Concerns
- Not Managing the Individual Budget according to Service Plan
- Inappropriate Utilization of Funds
- Consistent Non-Adherence to Program Policy
- Other (Describe) _____

To Be Completed by the Care Manager/Supports Coordinator

Reason for Disenrollment: _____

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

Care Manager/Supports Coordinator Signature

Date