Medicaid Home and Community Based Program Disenrollment Notice
Disenrollment Form DPF-1
New Choices Waiver

Waiver Program Name: New Choices Waiver		
CMA Name:	Contact Person:	Phone:
CMA Contact's Mailing Address:		

Client's Name:	Medicaid ID#:
Client's Date of Birth:	Client's Phone Number:
Representative Name (if applicable):	
Representative's Phone Number:	
Representative's Mailing Address:	

Client's residence type while enrolled in the waiver program:

☐ Private Home ☐ Private Apartment ☐ Assisted Living Facility, Type 1 or 2

☐ Memory Care/Secured Unit ☐ Independent Living Facility ☐ Other:

Facility Name (if applicable): _____

Date of waiver enrollment:	Date of waiver disenrollment:

Voluntary disenrollment: (Notify NCW within 10 calendar days of disenrollment)

☐ Client has chosen to voluntarily disenroll from the New Choices Waiver program.

Client's signature is required and cannot be substituted with a designated representative's signature unless the client has been previously assessed to be unable to make informed decisions as verified by a clinician or by legal documentation. Attach signed clinician statement or signed legal documentation.

Client's Signature: _____ Date: _____

Representative's Signature: _____ Date: _____

Representative's Authority: _____

Client's new address (if known):

Client's new phone number (if known):

Pre–Approved Involuntary Disenrollment: (Notify NCW within 10 calendar days of disenrollment)

Client must be disenrolled from the New Choices Waiver program for the following reason:

☐ Death of the client (Date: _____) Was the client receiving hospice services? ☐Yes ☐No

Cause/circumstances of death: _____

☐ Client has been determined to no longer meet the financial requirements for Medicaid eligibility by the Department of Workforce Services

☐ Client has entered an inpatient setting and the expected length of stay will exceed 90 days (as verified by a physician– attach signed physician statement)

Date of inpatient admission: _____ Name of inpatient setting: _____

☐ Client has entered an inpatient setting and the actual length of stay has reached or exceeded 90 days

Date of inpatient admission: _____ Name of inpatient setting: _____