

**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 Phone Number:	
Representative Name (if applicable):	
Representative's Phone Number:	
Representative's Mailing Address:	
Client's residence type while enrolled in the waiver program: <input type="checkbox"/> Private Home <input type="checkbox"/> Private Apartment <input type="checkbox"/> Assisted Living Facility, Type 1 or 2 <input type="checkbox"/> Memory Care/Secured Unit <input type="checkbox"/> Independent Living Facility <input type="checkbox"/> Other: Facility Name (if applicable): _____	
Date of waiver enrollment:	Date of waiver disenrollment:

Voluntary disenrollment: (Notify NCW within 10 calendar days of disenrollment)
<input type="checkbox"/> Client has chosen to voluntarily disenroll from the New Choices Waiver program. <i>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.</i> 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:
<input type="checkbox"/> Death of the client (Date: _____) Was the client receiving hospice services? _____ Cause/circumstances of death: _____ <input type="checkbox"/> Client has been determined to no longer meet the financial requirements for Medicaid eligibility by the Department of Workforce Services <input type="checkbox"/> 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: _____ <input type="checkbox"/> 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: _____