Michigan Department of Health and Human Services

MI CHOICE WAIVER DISENROLLMENT NOTIFICATION

INSTRUCTIONS

This form must be used by MI Choice waiver agencies to notify local Michigan Department of Health and Human Services (MDHHS) 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 MDHHS 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 MDHHS 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 MDHHS.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

MI CHOICE WAIVER DISENROLLMENT NOTIFICATION

Waiver Agency Name (Select One):	
Medicaid Provider ID Number:	
Phone Number: ( ) -	Fax Number: ( ) -
Contact Person:	

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**

MDHHS County Office (Select One): None Selected District Number: _____

Date of MDHHS Office Notification: _____

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

Other: _____

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The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.