

**DODD Notification of Individual Change in Status (NICS) – Part 2  
DISENROLLMENT/WITHDRAWAL FROM WAIVER PROGRAM**

<b>Individual First Name:</b>	<b>Individual Last Name:</b>	<b>County:</b>
<b>DODD #:</b>	<b>SSN:</b>	<b>Current Waiver Type:</b> <input type="checkbox"/> LV1 <input type="checkbox"/> I/O <input type="checkbox"/> SELF <input type="checkbox"/> TDD

**Note:**

- Please select the “Reason” that best describes the disenrollment in HCBS waiver or withdrawal of the initial application.
- The “Voluntary” reason should only be selected when the individual or guardian no longer wants waiver services and there is no other reason in rule or law that is applicable.
- Individual or guardian signatures are required for all “Voluntary” disenrollments and “Voluntary” withdrawals of an initial application, including a change of waiver.
- Individual or guardian signatures are strongly recommended for all other disenrollment reasons, except death.

**Waiver Disenrollment/Withdrawal of Initial Application**

<p><b><u>Supporting Documentation is Required for All of the following Disenrollments:</u></b></p> <input type="checkbox"/> Nursing Facility <input type="checkbox"/> ICF/IID <input type="checkbox"/> Jail/Incarceration <input type="checkbox"/> No Medicaid Program Eligibility <input type="checkbox"/> Moved Out of State <input type="checkbox"/> Refused to Cooperate with Assessment <input type="checkbox"/> Failure or Refusal to use waiver services <input type="checkbox"/> Health and Safety cannot be assured <input type="checkbox"/> Voluntary (complete ‘Voluntary Only’ section below) <input type="checkbox"/> Other: (please explain)	<b>Facility Name (If applicable):</b>
	<input type="checkbox"/> <b>Disenrollment Due to Death</b>
	<p><b>Date of Death:</b></p> <p><b>Place of Death:</b></p> <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Home <input type="checkbox"/> Other: (explain below)

**Comments:**

**Voluntary Only:**  Individual and /or legal guardian has made an informed choice for disenrollment.  
**Signature date below will be date of disenrollment for voluntary only.**

**Payment Authorization of Services (PAWS)** Submit completed form and all required documentation to the PAWS unit

**PAWS Last Date of Waiver Services:**

**Change of DODD Waiver:** Submit initial application packet along with this form

<b>Current Waiver:</b> <input type="checkbox"/> LV1 <input type="checkbox"/> I/O <input type="checkbox"/> SELF <input type="checkbox"/> TDD <b>Proposed Disenrollment Date:</b>	<b>New Waiver:</b> <input type="checkbox"/> LV1 <input type="checkbox"/> I/O <input type="checkbox"/> SELF <input type="checkbox"/> TDD <b>Proposed Waiver Begin Date:</b>
--	---

**Signatures Required Below**

I \_\_\_\_\_, (individual, or legal guardian), do hereby request the Ohio Department of Developmental Disabilities to discontinue the enrollment or the pursuit of enrollment as noted above in this document.

\_\_\_\_\_  
**Individual/Guardian Signature**

\_\_\_\_\_  
**Signature Date**

<b>Email:</b>	<b>Completed by:</b>	<b>Date:</b>
<b>DODD Use:</b>	<b>Waiver Manager:</b> <input type="checkbox"/> <b>Send PRNO</b>	<b>Disenrollment date:</b> 15 days from PRNO letter
		<b>P/R Initials:</b>