

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

Individual First Name:		Individual Last Name:		County:
DODD #:	SSN:	Current Waiver Type: <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><u>Supporting Documentation is Required for All of the following Disenrollments:</u></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)	Facility Name (If applicable):
	<input type="checkbox"/> Disenrollment Due to Death
	<p>Date of Death:</p> <p>Place of Death:</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

Current Waiver: LV1 I/O SELF TDD
Proposed Disenrollment Date:

New Waiver: LV1 I/O SELF TDD
Proposed Waiver Begin Date:

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

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