



**FOR RESOURCE CENTER AND MCO OFFICE USE ONLY**

Please check the appropriate box below to indicate whether this form is being used for a disenrollment due to a loss of eligibility, Box 22, or an involuntary disenrollment, Box 30, or a voluntary disenrollment, Box 32.

**If this form is being used for a disenrollment due to a loss of eligibility or to an involuntary disenrollment, then:**

- The enrollee, or his or her guardian or activated POAHC if there is one, should **not** sign or date the statement of intent to voluntarily disenroll on the front of this form and should **not** sign or date the form anywhere else
- Boxes 1-8 and Boxes 10-12 should be filled in by resource center and/or MCO staff
- The effective date of disenrollment given in Box 12 should be based on the applicable Medicaid and Family Care policies and procedures, e.g., the effective date of disenrollment due to a loss of financial eligibility should be based on the applicable adverse action logic
- Box 9 as well as Boxes 13-21 should be left blank or marked N/A

**If this form is being used for a disenrollment due to a voluntary disenrollment by an enrollee, then:**

- The enrollee or his or her guardian or activated POAHC should sign and date the statement of intent to voluntarily disenroll on the front of this form
- Boxes 10-12 **must** be filled in by resource center staff; staff may, of course, help the enrollee fill in other boxes or even fill them in for the enrollee if requested to do so by the enrollee
- The effective date of voluntary disenrollment chosen by the enrollee, which is entered in Box 12, should not be earlier than the date on which the enrollee or his or her guardian or activated POAHC signs the statement of intent to voluntarily disenroll unless the MCO can provide a justification for using an earlier date.

Name of Managed Care Organization:
Name of Enrollee (First Name, MI, Last Name):

22. <input type="checkbox"/> Loss of Eligibility Please indicate the reason for the loss of eligibility by checking the appropriate box below	
23. <input type="checkbox"/> Loss of financial eligibility	24. <input type="checkbox"/> Loss of functional eligibility
25. <input type="checkbox"/> Failure to pay cost share	26. <input type="checkbox"/> Incarceration or placement in an IMD
27. <input type="checkbox"/> Move out of the county in a single-county MCO or out of the service area in a multi-county MCO	28. <input type="checkbox"/> Death: Date of death/disenrollment: (MM/DD/YYYY)
29. <input type="checkbox"/> Other: (Please describe)	
30. <input type="checkbox"/> Involuntary Disenrollment	
31. Date involuntary disenrollment was approved by DHFS: (MM/DD/YYYY)	
32. <input type="checkbox"/> Voluntary Disenrollment	