INDEPENDENT LIVING SUPPORTS PILOT (ILSP) PARTICIPANT DISENROLLMENT

Instructions: To be completed by aging and disability resource center (ADRC) staff on participant's disenrollment from the ILSP program prior to 12 months or exhaustion of funding. Personally identifiable information will be shared with the fiscal agent to stop payment of ILSP program claims.

I. PERSONAL INFORMATION

Name (Last, First, MI)	Date of Birth	ILSP ID	ADRC

II. DISENROLLMENT

☐ The individual has become ineligible for the ILSP program and will be disenrolled.

Reason:

- ☐ Individual moved outside of ADRC's service area
- ☐ Individual moved to a licensed or certified facility
- ☐ Individual enrolled in a long-term care Medicaid program
- ☐ Loss of contact
- ☐ Individual passed away
- ☐ _____

Name (Last, First, MI)	Date of Birth	ILSP ID	ADRC

I agree to disenrollment in the ILSP program effective on the date of my signature below. I understand that no claims incurred past this date will be paid by the ILSP program.

SIGNATURE – Applicant	Date Signed
SIGNATURE – Legal Guardian, Conservator, or Activated Power of Attorney	Date Signed
SIGNATURE – Legal Guardian, Conservator, or Activated Power of Attorney	Date Signed
SIGNATURE – Witness (if applicable)	Date Signed
SIGNATURE – Witness (if applicable)	Date Signed

III. INFORMATION COMPLETED BY

Name – ADRC Worker	Date Completed
Phone Number	Email Address