Services My Way
Disenrollment Form

Name of Participant: _____

Medicaid #:_____SS#:_____DOB:_____

Name of Representative (If Necessary):_____

For voluntary or involuntary termination of SMW, attach a revised service plan

☐ Voluntary Termination of SMW

I, _____
am voluntarily discontinuing my participation in the Services My Way service model. I understand that I will return to traditional agency provided services at this time, but if I decide I want to return to Services My Way at any time, I may contact my Care Manager/Supports Coordinator to discuss my re-enrollment.

_____ _____
Participant Signature Date

_____ _____
Representative Signature Date

_____ _____
Care Manager/Supports Coordinator Signature Date

☐ Involuntary Termination of SMW

Reason for involuntary termination:
☐ Health and Safety Concerns
☐ Not Managing the Individual Budget according to Service Plan
☐ Inappropriate Utilization of Funds
☐ Consistent Non-Adherence to Program Policy
☐ Other (Describe) _____

To Be Completed by the Care Manager/Supports Coordinator

Reason for Disenrollment: _____

_____

What referrals have been made to assure that personal care needs are met for this individual?

_____

_____

_____ _____
Care Manager/Supports Coordinator Signature **Date**