☐ SSI

New Jersey Department of Human Services

NOTICE OF PROGRAM DISENROLLMENT

To: _____ Date: _____

☐ CWA / Board of Social Services *(CP-23 not sent to CWA if on SSI)*
☐ DHS Regional Office, Office of Community Choice Options (OCCO)

From: _____

☐ Care Manager ☐ OCCO Field Office Manager (FOM) ☐ PACE Administrator

_____
Address

_____
Phone

This notice advises you that the individual identified below has been disenrolled from a Medicaid Waiver Program, Global Options, or PACE, as specified below. Please prepare and submit the appropriate Medicaid Status File input documents in accordance with related Operational Procedures.

Name:	Medicaid No.:
Street Address:	Disenrollment Date:
City, State, Zip Code:	Participant Receives SSI Benefits? ☐ Yes ☐ No
Check One: ☐GO ☐PACE ☐ Other, Specify: _____	

Reason(s) for Disenrollment:

- ☐ Participant is deceased. Date of Death:
- ☐ Participant has chosen to reside in a nursing facility for long-term care or hospice services.
- ☐ Participant no longer meets the clinical eligibility criteria for nursing facility level of care under the New Jersey Medicaid Program in accordance with N.J.A.C. 8:85-2.1.
- ☐ The services required by the participant to be adequately cared for under the program specified above are not available in the program.
- ☐ Participant has resided out of the service area for more than 30 days without prior authorization.
- ☐ Participant voluntarily withdraws from the program specified above, for the reason(s) indicated:
  - ☐ The services do not meet my needs
  - ☐ I want to receive services in an institutional setting, and I would like the Office of Community Choice Options to assist me. I understand that I will continue to receive services under the waiver program or PACE program until I enter an appropriate setting.
  - ☐ I have been counseled on benefits for which I may be eligible and meet my needs.
  - ☐ Other: _____

_____ _____
(Signature of Participant) (Date)

- ☐ Participant never received services under the program, including care management.
- ☐ Participant refuses to accept two waiver services as required.
- ☐ Participant was transferred to and enrolled in another Medicaid Waiver:

_____ effective _____
(Name of Program) (Enrollment Date)

- ☐ Other: _____

Name of Care Manager, OCCO FOM or PACE Administrator (Print)	Signature

c: ☐ Participant ☐ Contact Person ☐ Care Management Site ☐ PACE Provider Organization ☐ OCCO File