

**Medicaid Home and Community Based Program  
Special Circumstance Involuntary Disenrollment Notice of Intent**

<b>Program:</b>	
<b>Program Contact Person:</b>	<b>Phone:</b>
<b>Address:</b>	
<b>Client Name:</b>	<b>Phone:</b>
<b>Medicaid ID#:</b>	
<b>Legal Guardian Name: (if applicable)</b>	<b>Phone:</b>
<b>Client Address/Residence Type:</b>	
_____	
Street Address	Apt. #
City,	State,
Zip Code	
<b>Current Residence Type (Circle):</b>	
Home	Apartment
Supervised Apartment	
Assisted Living	Nursing Facility
ICF/MR	
<b>Date of Enrollment:</b>	<b>Date of Intended Disenrollment:</b>
<b>Special circumstance involuntary disenrollments:</b>	
<b>Individual:</b>	
<input type="checkbox"/> no longer meets corresponding institutional level of care requirement: nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR)	
<input type="checkbox"/> health and safety needs cannot be met by the current program's services and supports	
<input type="checkbox"/> has demonstrated non-compliance with the agreed upon care plan/support plan and is unwilling to negotiate a plan of care that meets minimal safety standards	
<input type="checkbox"/> poses an imminent danger to themselves or others	



