

**Division of Health Care Financing Decision Notice  
for Special Circumstance Involuntary Home and Community Based  
Program Disenrollment**

**TO:**

Program name:	
Program contact person:	Phone:
Address:	

**RE:**

Client name:	Phone:			
Medicaid ID#:				
Legal guardian name: (if applicable)	Phone:			
Client address:				
_____				
Street Address	Apt. #	City,	State,	Zip Code

Based upon the information provided by the Special Circumstance Involuntary Disenrollment Notice of Intent submitted to the Division of Health Care Financing, the following decision has been made:

- Proceed with notice of agency action, including information related to right to appeal.
- With the client's consent, refer and assist in the transition planning into \_\_\_\_\_ program.
- Do not proceed with discharge
  - Initiate coordination of other resources:**

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_____
_____
_____

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_