Move to Discharge Form

Name: _____ DDD ID #_____

I, _____ wish to voluntarily disenroll from Division services, including waiver services as of this date _____. I understand that my disenrollment will cause me to lose all my current services funded through The Division of Developmental Disabilities. If I so choose to enroll back into Division services, I understand that I will have to be Medicaid eligible, meet the functional criteria, and be a New Jersey resident. I also acknowledge that I will have to go through the entire intake process again.

My disenrollment is due to the following reasons (optional): _____

_____

_____

Support Coordination Agency: _____

Individual Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____