# Department of Human Services
Division of Aging Services
Office of Community Choice Options

## MLTSS Voluntary Withdrawal Form

**Send ALL MLTSS voluntary withdrawal forms to Doas.Trenton@dhs.state.nj.us for processing.**

**All sections with an * are required information. If they are not filled out the form will not be processed and returned.**

| | |
|---|---|
| *Date of Request: | *MCO Name: |
| *Participant Name: | *Medicaid Number: |
| *Participant Phone #: | *Date of Birth: |
| *Participant Address: | |
| Date of Enrollment: | Program Status Code: |
| *Participant's Legal Representative's Name, Relation, Phone Number: | |
| *MCO Care Manager/OCCO Assessor: | *Phone #: |
| *MCO Supervisor Name: | *Phone Number: |

**Note: This process does not include individuals who are known to have moved out of the state or service area, expired (Article 5); erroneously enrolled into MCO while in an inpatient Hospital setting, or wish to switch MCO plans.**

I (or authorized representative) understand that I (or authorized representative) am requesting to voluntarily withdraw from Managed Long Term Services and Supports (MLTSS) for the reason(s) indicated below.

Counseling has been provided by the Managed Care Organization (MCO) Care Manager or the Division of Aging Services Clinical Assessor on the services covered under MLTSS which will no longer be available due to the request to withdraw from MLTSS. The withdrawal may also include loss of NJ FamilyCare eligibility if financial eligibility was based on the higher institutional financial income limit for MLTSS (2018: gross monthly income is between $1012.00 and $2,250.00).

Counseling has been provided by the MCO Care Manager or the Division of Aging Services Clinical Assessor on other programs or services for which I may be eligible and will meet my needs, including how to contact the Aging and Disability Resource Connection in my county to access those programs or services. I understand that I may reapply for MLTSS and have been advised of whom to contact to reapply and their phone number(s).

☐ **I do not want MLTSS services including Care Management. I understand that I will have to be re-evaluated for NJ Family Care eligibility under another NJ Family Care program and may lose NJ Family Care eligibility.**

☐ I want to receive services through a different program (specify): _____

☐ **Participant/Representative gave verbal consent to withdrawal but declined to sign Form.**

☐ ***Second Request for Disenrollment: Counseling completed and member requested disenrollment from MLTSS:***
(Summary of Options Counseling with dates)

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|---|
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| |

(Participant/Representative Signature) (Date)

(*MCO Care Manager or OCCO Assessor Signature) (Date)

(*MCO Supervisor Signature if applicable) (Date)

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Participant Name: _____

*Medicaid Number: _____ *Date of Birth: _____

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***For State Use Only:***

OCCO Date of Receipt: _____

Outreach to member needed: ☐ YES (PSC: 120, 220, 520)

Date of Outreach: _____

Name and Relationship of individual contacted: _____

☐ Member wishes to continue MLTSS benefits (specify below):

_____

_____

_____

Date MCO Notified: _____

☐ No Outreach needed:

Date of Clinical Termination: _____

Date Notification Sent: _____

☐ DMAHS Managed Care Account Coordinators Unit: Managedcare.Accounts@dhs.state.nj.us

☐ DMAHS County Operations Office: David.Powers@dhs.state.nj.us