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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-00221 (02/2024) |  | **STATE OF WISCONSIN** |
| **Family care or IRIS member or Participant requested disenrollment OR Transfer InSTRUCTIONS** | | |
| **Section A—Personal Information**  This section is to be completed by the aging and disability resource center (ADRC) or Tribal aging and disability resource specialist (ADRS) based upon the individual’s information in ForwardHealth.  The ADRC or Tribal ADRS should verify the contact information in this section and make any necessary corrections. When income maintenance (IM) receives the form showing corrections they will update the information in CARES. If the individual receives Supplemental Security Income (SSI), the ADRC or Tribal ADRS should prompt the individual to contact the Social Security Administration (SSA) to update the information.  **Section B—Disenrollment Request**  This part of the form is to be completed by the ADRC or Tribal ADRS. The individual indicates the program they wish to leave and the disenrollment date they would prefer. It is important for the ADRC or Tribal ADRS to provide all relevant information to the individual during disenrollment counseling, such as the impact on Medicaid eligibility and how the date effects cost share, to allow the individual to make an informed decision.  The ADRC or Tribal ADRS staff will fill in the Effective Date of Disenrollment. The ADRC or Tribal ADRS will enter the effective date of disenrollment in FHiC. The ICA will enter the effective date of disenrollment in WISITS. The date the individual wishes to disenroll from the program may not always be the actual disenrollment date, especially for immediate disenrollment requests. If an individual wishes to disenroll from a program in less than three business days from the date the form is signed, the ADRC or Tribal ADRS will contact the MCO or ICA to expedite the process.  **Section C—Transfer Request**  This part of the form is to be completed by the ADRC or Tribal ADRS. The individual indicates the program and MCO or ICA they wish to transfer to. If the request is due to a recent move, they are asked for their new address, phone number and the effective date of the move. A new enrollment or referral from is required when an individual chooses to transfer to a new program, MCO, or ICA. If enrolling in a new program or agency as a result of a move, the enrollment date will be left blank initially and will be completed when the enrollment date is determined by the long-term care program agencies.  If the individual is choosing to enroll in Family Care, PACE, or Partnership, the ADRC or Tribal ADRS will enter the new enrollment date on the form, the enrollment date is selected by the individual. The ADRC or Tribal ADRS will also enter the new enrollment date in FHiC.  If the individual is choosing IRIS, the ADRC or Tribal ADRS will enter the IRIS referral date on the form. The IRIS start date is determined by the ICA and will be entered in WISITS. If the individual is transferring from Family Care, PACE, or Partnership to IRIS the disenrollment date should not be entered on the form or in FHiC until the start date is received from the ICA. If an IRIS participant is choosing to transfer from ICA to ICA, the participant may choose to remain with the current FEA or select a new FEA. If the participant chooses to select a new FEA, complete form [F‑02764](https://www.dhs.wisconsin.gov/forms/f02764.docx).  The information provided will determine, what entity is to be informed of the transfer and if a Family Care Program Enrollment Form, PACE Program Enrollment Form, Partnership Program Enrollment Form or IRIS Authorization Form will need to be completed.  **Section D—Reason for Disenrollment or Transfer Request**  In this section, the individual may voluntarily indicate to the ADRC or Tribal ADRS the primary reason for wanting to leave their current program, ICA or MCO.  **Section E—Grievance or Appeal**  An important part of disenrollment counseling is assisting the individual to understand and exercise all their rights as members and program participants. Depending upon the individual’s reason for wanting to leave the program, they may have the right to file an appeal. All individuals have the right to file a grievance. ADRC or Tribal ADRSs can provide assistance to anyone who wishes to file an appeal or grievance. ADRCs or Tribal ADRSs can explain to individuals who may be in the appeal process and the consequences of disenrollment prior to completion of the appeal. All MCOs have Member Rights Specialists who assist members with filing appeals and grievances. For more information about filing an appeal or grievance, individuals may review the MCO Member Handbook or the IRIS Participant Handbook.  **Section F—Authorization to Release Information**  Complete this section when the individual is requesting to transfer to a new agency or long-term care program. This section (1) informs the individual that their Long-Term Care Functional Screen information can be transferred to the new agency without the individual’s informed consent under Wis. Stat. § 46.284(7); and (2) documents the individual’s authorization for the current agency or long-term care program to share the specified confidential information with the new chosen program or agency. The signature of the individual, legal guardian, conservator or activated power of attorney authorizes the release of the information specified in section F of the form.  **Section G—Signature**  MCO members and IRIS program participants must sign this section of the form to be disenrolled from long-term care or to be transferred to another long-term care program, MCO or ICA even if they do not complete any other section. If the individual receiving services is incapacitated, the individual cannot sign the disenrollment form; instead, the individual’s legal guardian, conservator, or activated power of attorney must sign the form. If the person signs with a mark, two witness signatures are required. If the person is physically unable to sign, the person can direct an adult to sign the form in front of two witnesses. The person who signs should indicate that they are signing at the direction of the applicant or member.  **Section H—Information Completed By**  This section is filled out by the ADRC or Tribal ADRS to identify who completed the form and to provide individuals with the ADRC’s or Tribal ADRS’s contact information.  **Section I—ICA Use**  This section is filled out by the ICA when the participant is transferring from IRIS to Family Care, Partnership or PACE. The ICA must verify the date of disenrollment as provided on this form and enter the date in which the disenrollment date was entered in WISITS. This form should be sent back to the ADRC or Tribal ADRS when completed by the ICA.  **Form Distribution and Routing Information**  Once all pages of the form are completed, the ADRC or Tribal ADRS must route the form to the following parties:   * Member/Participant * Current and requested ICA or MCO * Tribe if applicable * IM – Route to IM in the following situations when the individual is:   + Transferring due to a recent move and their new address is not displayed in FHiC if member or participant is open in CARES.   + Disenrolling from Family Care or IRIS and is receiving MA through Community Waiver MA eligibility or MAPP   The ADRC or Tribal ADRS must retain the originally signed member or participant requested disenrollment form, or an electronically scanned copy of the signed form, for ten years in the event of a records request. | | |

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| **STATE OF WISCONSIN**  **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-00221 (02/2024) | | | | | | | | **CIP** | | | | | | | | | | | |
| **Family care or IRIS**  **member or PARTICIPANT requested disenrollment or Transfer** | | | | | | | | | | | | | | | | | | | |
| To be completed by aging and disability resource center (ADRC) or tribal aging and disability resource specialist (ADRS) for use by local income maintenance (IM), managed care organization (MCO) and IRIS consultant agency (ICA). | | | | | | | | | | | | | | | | | | | |
| **A. PERSONAL INFORMATION** | | | | | | | | | | | | | | | | | | | |
| Name – First | | | | | | MI | | | Last | | | | | | | | | | |
|  | | | | | |  | | |  | | | | | | | | | | |
| Street Address | | | | | | | | | City | | | | | | | | | Zip Code | |
| County of Residence | | | | | | | | | County of Responsibility | | | | | | | | | | |
| American Indian or Alaskan Native  Yes  No | | | | | | | | | American Indian/Alaskan Native Affiliation | | | | | | | | | | |
| Phone Number | | | | | | | | | Cell Phone Number | | | | | | | | | | |
| Date of Birth | | Member ID No. (as shown in ForwardHealth) | | | | | | | | | | Individual Target Group  FE  ID or DD  PD | | | | | | | |
| Guardian  Spouse  Conservator  POA  Other: | | | | | | | | | | | | | | | | | | | |
| Name of Contact | | | | | | | | | Phone Number | | | | | | Cell Phone Number | | | | |
| Street Address | | | | | | | | | City | | | | | | | | | Zip Code | |
| Current Long-Term Care (LTC) Program  Family Care  IRIS | | | Name of MCO or ICA    Name of FEA | | | | | | | | | | | | | | | | |
| **B. DISENROLLMENT REQUEST** | | | | | | | | | | | | | | | | | | | |
| The individual requests to stop participation in the long-term care (checkprogram):  Family Care  IRIS | | | | | | | | | | | | | | | | | | | |
| The individual requests to stop participation on the following date:  (May not be Actual Date of Disenrollment) | | | | | | | | | | | | | | | | | | | |
| Effective Date of Disenrollment: | | | | | | | | | | | | | | | | | | | |
| **C. TRANSFER REQUEST** | | | | | | | | | | | | | | | | | | | |
| The individual is choosing to transfer to a new long-term care program or change to a new MCO or ICA, indicate program selected below:  Family Care  IRIS  Partnership  PACE  Different MCO  Different ICA  Requested MCO or ICA: | | | | | | | | | | | | | | | | | | | |
| Effective Date of Disenrollment: | | | | | | | | | | | | | | | | | | | |
| Effective date of new enrollment in Family Care, PACE, or Partnership:  or IRIS referral date (start date determined by ICA):  A new enrollment or referral form must also be completed | | | | | | | | | | | | | | | | | | | |
| If this transfer request is a result of a move, please complete the information below for the new address: | | | | | | | | | | | | | | | | | | | |
| Street Address | | | | | | | | | | | City | | | | | | | | Zip Code |
| County of Residence | | | | Phone Number | | | | | | | | | Effective Date of Move | | | | | | |
| **D. REASON FOR DISENROLLMENT OR TRANSFER REQUEST** | | | | | | | | | | | | | | | | | | | |
| Select the primary reason the member or participant is choosing to disenroll or transfer to a different long-term care program, MCO or ICA: | | | | | | | | | | | | | | | | | | | |
| 7E Dissatisfied with cost share | | | | | | | | | | 7M Choosing Nursing Home or Hospice Services | | | | | | | | | |
| 7A Difficulty finding or retaining providers | | | | | | | | | | 7D Switching to fee-for-service Medicaid | | | | | | | | | |
| 7B Needed additional support in coordinating services and/or supports | | | | | | | | | | 70 Moved to another service region | | | | | | | | | |
| 7B Unable to secure all needed services or hours of service | | | | | | | | | | Moved Out of State | | | | | | | | | |
| 7A Not able to use provider of choice | | | | | | | | | | 7B Services did not meet expectations | | | | | | | | | |
| 7L Customer service issues with the MCO or IRIS Consultant Agency or IRIS Fiscal Employer Agency | | | | | | | | | | 72 Chose not to provide reason | | | | | | | | | |
| Services no longer needed | | | | | | | | | |  | | | | | | | | | |
| **E. GRIEVANCE OR APPEAL** | | | | | | | | | | | | | | | | | | | |
| Has the member or participant filed a grievance or appeal with the MCO or IRIS review committee or another party related to your wish to disenroll?  Yes  No | | | | | | | | | | | | | | | | | | | |
| **F. RELEASE OF INFORMATION** | | | | | | | | | | | | | | | | | | | |
| **I understand that that Wis. Stat. §46.284(7) allows for the above selected agency to be provided with my Long-Term Care Functional Screen (LTCFS) information without my informed consent.**  I authorize that the above selected agency be given access to the following information to help me enroll in my new program or agency:   * My current Individual Support and Service Plan (ISSP) or Member Centered Plan (MCP) * My Behavior Support Plan and/or Restrictive Measure, if applicable * Documents establishing the authority of my legal guardian, conservator or activated power of attorney, if applicable * Court orders, if applicable * Crisis plan, if applicable   Other – Specify: | | | | | | | | | | | | | | | | | | | |
| **SIGNATURE** – Member/Participant | | | | | | | | | | | | | | | | Date Signed | | |
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| **SIGNATURE –** Legal Guardian, Conservator, or Activated Power of Attorney | | | | | | | | | | | | | | | | Date Signed | | |
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| **SIGNATURE** – Witness (If applicable) | | | | | | | | | | | | | | | | Date Signed | | |
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| **SIGNATURE** – Witness (If Applicable) | | | | | | | | | | | | | | | | Date Signed | | |
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| **G. STATEMENT OF INTENT—You must sign this statement of intent to disenroll or transfer** | | | | | | | | | | | | | | | | | | | |
| I, the undersigned, have either requested to no longer participate in a long-term care program and request to be disenrolled or I have requested to transfer to another long-term care program, MCO or ICA. I understand that if I am requesting to enroll in IRIS, disenrollment from my current program will not occur until my IRIS service plan is approved. **Your request for disenrollment or transfer will not be processed if you do not sign below**. | | | | | | | | | | | | | | | | | | | |
| **SIGNATURE** – Member/Participant | | | | | | | | | | | | | | | | Date Signed | | |
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| **SIGNATURE –** Legal Guardian, Conservator, or Activated Power of Attorney | | | | | | | | | | | | | | | | Date Signed | | |
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| **SIGNATURE** – Witness (If Applicable) | | | | | | | | | | | | | | | | Date Signed | | |
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| **SIGNATURE** – Witness (If Applicable) | | | | | | | | | | | | | | | | Date Signed | | |
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| **H. INFORMATION COMPLETED BY** | | | | | | | | | | | | | | | | | | | |
| ADRC or Tribe Name | | | | | | | | | | | | | | County | | | | | |
| ADRC or Tribal ADRS Mailing Address | | | | | | | City | | | | | | | Zip Code | | | | | |
| Name – ADRC or Tribal ADRS Worker | | | | | | | | | | | | | | Phone Number | | | | | |
| Email Address | | | | | | | | | | | | | | | | | | | |
| **ADRC or Tribal ADRS should send all pages of completed form even if disenrollment counseling is not provided.**  The ADRC or Tribal ADRS must retain the originally signed member or participant requested disenrollment form, or an electronically scanned copy of the signed form, on file for ten years in the event of a records request.  Distribution of completed form:  Individual, Guardian, Conservator, or Activated Power of Attorney  Current and requested MCO or ICA  IM (see instructions)  Tribe if applicable | | | | | | | | | | | | | | | | | | | |
| **I. ICA Use Only**  **This section to be completed by the ICA if the participant is transferring from IRIS to Family Care, Partnership or PACE. The form should be sent back to the ADRC when completed.** | | | | | | | | | | | | | | | | | | | |
| Name – ICA | | | | | Name – Staff Person | | | | | | | | | | | Date | | | |
| IRIS Disenrollment Date: | | | | | | Date Disenrollment entered in WISITS: | | | | | | | | | | | | | |