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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-00534LP (02/2024) | **STATE OF WISCONSIN** |
| **Partnership**  **member 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 should verify the contact information in this section and make any necessary corrections on the form. 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 may affect 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 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 Partnership Organization to expedite the process.  Medicare benefits under the individual’s current Partnership plan may continue for a period of up to three months following their disenrollment or transfer request. The start date of their new coverage depends upon Special Election Period (SEP) eligibility. Individuals disenrolling from Partnership may elect to enroll in a new Medicare Advantage plan or a stand-alone Medicare Part D plan. If an individual does not take action to enroll in another Medicare plan before the Partnership coverage ends, they will be auto enrolled in Original Medicare and may risk going without prescription drug coverage. The individual should contact their current Medicare plan to obtain more information about SEP eligibility.  For help with Medicare options, the individual may schedule an appointment with the benefit specialist at the ADRC, the Tribal benefit specialist or call the Wisconsin Medigap Helpline at 1-800-242-1060.  **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, the individual is asked for their new address, phone number and the effective date of the move. A new enrollment or referral from is required when a customer 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.  The information provided in this section 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 an IRIS Authorization Form will need to be completed.  Medicare benefits under the individual’s current Partnership plan may continue for a period of up to three months following their disenrollment or transfer request. The start date of their new coverage depends upon Special Election Period (SEP) eligibility. Individuals disenrolling from Partnership may elect to enroll in a new Medicare Advantage plan or a stand-alone Medicare Part D plan. If an individual does not take action to enroll in another Medicare plan before the Partnership coverage ends, they will be auto enrolled in Original Medicare and may risk going without prescription drug coverage. The individual should contact their current Medicare plan to obtain more information about SEP eligibility.  For help with Medicare options, the individuals may schedule an appointment with the benefit specialist at the ADRC, Tribal benefit specialist or call the Wisconsin Medigap Helpline at 1-800-242-1060.  **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 or PO.  **Section E—Grievance or Appeal**  An important part of disenrollment counseling is assisting the individual to understand and exercise all his or her 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. ADRCs or Tribal ADRSs can provide assistance to anyone who wishes to file an appeal or grievance. ADRCs or Tribal ADRS should explain to individuals who may be in the appeal process the consequences of disenrollment prior to completion of the appeal. All POs 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 Partnership Member 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**  Partnership members 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.  **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:   * Member * Current and requested PO, MCO or ICA * 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 is open in CARES.   + Disenrolling from Partnership and is receiving MA through Community Waiver MA eligibility or MAPP   The ADRC or Tribal ADRS must retain the original 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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| **partnership**  **CIP**  **member requested disenrollment OR TRANSFER** | | | | | | | | | | | | | | |
| To be completed by ADRC or Tribal ADRS for use by local IM and PO. | | | | | | | | | | | | | | |
| **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 | | | | | | |
| Name of Contact Person | | | | | | Phone Number | | | | | Cell Phone Number | | | | |
| Guardian  Spouse  Conservator  POA  Other: | | | | | | | | | | | | | | | |
| Street Address | | | | | | City | | | | | | | | Zip Code | |
| Name of MCO | | | | | | | | | | | | | | | |
| **B. DISENROLLMENT REQUEST** | | | | | | | | | | | | | | | |
| The individual requests to stop participation in the Partnership program (checkprogram):  My Choice Wisconsin Health Plan, Inc.  Community Care Health Plan, Inc.  Independent Care Health Plan | | | | | | | | | | | | | | | |
| 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 PO, indicate program selected below:  Family Care  IRIS  PACE  Different PO  Requested MCO, PO or ICA: | | | | | | | | | | | | | | | |
| Effective Date of Disenrollment: | | | | | | | | | | | | | | | |
| Effective date of new enrollment in Family Care, Partnership or PACE,  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 | | | | | |
| **Medicare Plan Election Date**  N/A: The individual does not qualify for Medicare.  SEP: The individual qualifies for a Special Election Period.  Effective date of Medicare plan election change:  No SEP: The individual does not qualify for a Special Election Period.  Effective date of Medicare plan election change: | | | | | | | | | | | | | | |
| **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, PO, 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 Partnership Organization | | | | | | | 72 Chose not to provide reason | | | | | | | | |
| Services no longer needed | | | | | | |  | | | | | | | | |
| **E. GRIEVANCE OR APPEAL** | | | | | | | | | | | | | | | |
| Has the member filed a grievance, or appeal with the PO review committee or another party related to their desire 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) / Member Centered Plan(MCP) * My Behavior Support Plan/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 | | | | | | | | | | | 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 or MCO. I understand that if I am requesting to enroll in IRIS that disenrollment from my current program will not occur until my IRIS service plan is approved.  **Important Note:** If you request disenrollment, you must continue to get all medical care from your plan until the effective date of disenrollment from the Medicare plan. Medicare benefits under your current Partnership plan will continue for a period of up to three months following your disenrollment or transfer request. The start date of your new coverage depends upon Special Election Period (SEP) eligibility. When you disenroll from Partnership, you may elect to enroll in a new Medicare Advantage plan or a stand-alone Medicare Part D plan. If you do not take action to enroll in another Medicare plan before Partnership coverage ends, you will be auto enrolled in Original Medicare and may risk going without prescription drug coverage. Contact your current Medicare plan for more information about SEP eligibility. For help with Medicare options, the individual may schedule an appointment with the benefit specialist at the ADRC, the Tribal benefit specialist or call the Wisconsin Medigap Helpline at 1-800-242-1060. | | | | | | | | | | | | | | |
| **SIGNATURE** – Member | | | | | | | | | | | 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 | | | | | | | | | | | | | County | | |
| ADRC/Tribe Mailing Address | | | | | City | | | | | | | | Zip Code | | |
| Name – ADRC or Tribal ADRS Worker | | | | | | | | | | | | | Phone Number | | |
| Email Address | | | | | | | | | | | | | | | |
| **ADRC or Tribal ADRS staff 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 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 PO, MCO or ICA  IM (see instructions)  Tribe if applicable | | | | | | | | | | | | | | | |