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| **STATE OF WISCONSIN****DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-02403 (10/2024)  | **CIP** |
| **Family care, partnership, pace, and IRIS****PROGRAM Requested Disenrollment** |

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| Managed care organization (MCO), IRIS consultant agency (ICA), PACE organization (PO), Bureau of Quality & Oversight (BQO), Income Maintenance (IM) Consortium, aging and disability resource center (ADRC) and tribal aging and disability resource specialist (Tribal ADRS). See instructions at the end of this form.**Note: All Family Care, Partnership, PACE and IRIS disenrollment requests using this form require the approval of the BQO Contract Coordinator or BQO Reviewer unless specifically noted.**  |
| **A. MEMBER OR PARTICIPANT INFORMATION All Programs** This section to be completed by the MCO, PO, or ICA. |
| Name – First      | MI      | Last      |
| Street Address      | City      | ZIP Code      |
| Name of Contact Person [ ]  Guardian [ ]  Spouse [ ]  Conservator [ ]  POA[ ]  Other:        |
| Street Address      | City      | ZIP Code      |
| County of Residence      | County of Responsibility      | Phone Number      |
| American Indian or Alaskan Native [ ]  Yes [ ]  No | American Indian/Alaskan Native Affiliation      |
| Member/Participant/Guardian Cell Phone Number      | Member/Participant/Guardian Fax Number      |
| Date of Birth      | Member ID No. (as shown in ForwardHealth)      | Member or Participant Target Group[ ]  FE [ ]  ID or DD [ ]  PD |
| Long-Term Care (LTC) Program[ ]  Family Care [ ]  Partnership [ ]  PACE [ ]  IRIS | Name of MCO, PO, or ICA      |
| **B. Managed Care Organization or Partnership Organization**[ ]  **No contact or no longer accepting services**[ ]  **Unable to assure health and safety** |
| [ ]  Check here to verify that that you have attached appropriate documentation supporting this request and that a certified letter has been sent to the member or participant 14 days prior to the date of this request. [ ]  Please check here if member or participant is unable to be located. |
| Date the member or participant last accepted services other than care management:        |
| **BQO Contract Coordinator** |
| Name – BQO Contract Coordinator      | Date Completed      |
| Email Address      | Phone Number      |
| Disenrollment Request Status:[ ]  Approved; Enter effective date of disenrollment:       [ ]  Denied; Return to MCO or PO  |
| **C. Managed Care Organization or Partnership Organization** [ ]  **Member acts that jeopardize MCO or PO** |
| [ ]  Check here to verify that you have attached appropriate documentation supporting this request and have sent copies of this documentation to the member.  |
| **BQO Contract Coordinator**  |
| Name – BQO Contract Coordinator       | Date Completed      |
| Email Address      | Phone Number      |
| Disenrollment Request Status:[ ]  Approved; Enter effective date of disenrollment:      [ ]  Denied; Return to MCO or PO only |
| **D. PACE Organization**[ ]  **Failure to pay pace premium**  |
| [ ]  Check here to verify that that the PACE member was provided with at least a 30-calendar day grace period to pay, or make arrangements to pay, the PACE premium due to the PACE organization. [ ]  Check here to verify that that you have attached appropriate documentation supporting this request. |
| **BQO Contract Coordinator** |
| Name – BQO Contract Coordinator       | Date Completed      |
| Email Address      | Phone Number      |
| Disenrollment Request Status:[ ]  Approved; Enter effective date of disenrollment:       [ ]  Denied; Return to PACE organizationNote: No updates to ForwardHealth or CARES are necessary for Section D disenrollments. Route only to the PACE organization and the ADRC for options counseling. |
| **E. PACE Organization** [ ]  **Caregiver acts that jeopardize the member, caregiver, or others**  |
| [ ]  Check here to verify that you have attached appropriate documentation supporting this request and have sent copies of this documentation to the member. |
| **BQO Contract Coordinator** |
| Name – BQO Contract Coordinator       | Date Completed      |
| Email Address      | Phone Number      |
| Disenrollment Request Status:[ ]  Approved; Enter effective date of disenrollment:       [ ]  Denied; Return to PACE organization |
| **F. IRIS Program Requested Disenrollments** |
| [ ]  Check here to verify that you have provided appropriate documentation supporting this request to BQO and have sent copies of this documentation to the participant. Exception: failure to pay cost share does not require BQO approval. [ ]  Reason for disenrollment:  |
| **BQO Reviewer** |
| Name – BQO Reviewer      | Date Completed      |
| Email Address      | Phone Number      |
| Disenrollment Request Status:[ ]  Approved; Enter effective date of disenrollment:      [ ]  Denied; Return to ICA only[ ]  Request does not require BQO Approval; Enter effective date of disenrollment:       |
| **G. REQUEST COMPLETED FOR MCO, PO, or ICA BY** |
| Name – MCO, PO, or ICA Worker      | Date Completed      |
| Email Address      | Phone Number      |
| **H. REFERRAL TO IM CONSORTIUM AND ADRC or Tribal ADRS** |
| **MCO, PO, or ICA**: Date routed to IM and ADRC or Tribal ADRS and tribe if applicable:       |
| **INSTRUCTIONS****MCO**—Initiate disenrollment process by completing Section A, Section B or C. Submit this form along with appropriate supporting documentation to your assigned BQO Contract Coordinator for disenrollment. When the approval of the disenrollment is received from the Contract Coordinator, complete Section H and send to the IM consortium, ADRC, and Tribe if applicable.**PO**—Initiate disenrollment process by completing Section A, B, C, D or E. Submit this form along with appropriate supporting documentation to your assigned BQO Contract Coordinator for disenrollment. When the approval of the disenrollment is received from the Contract Coordinator, complete Section H and send to the IM consortium, ADRC, and Tribe if applicable.**ICA**—Initiate disenrollment process by completing Section A and Section F. Submit this form to your assigned BQO Reviewer for disenrollment if required. When the approval of the disenrollment is received from the BQO Reviewer, complete Section H and send to the IM consortium, ADRC, and Tribe if applicable.**BQO Contract Coordinator—**Review request submitted by MCO or PO. Complete Section B, C, D or E. Send completed form to the MCO or PO. **BQO Reviewer—**Review request submitted by ICA. Complete Section F. Send completed form to the ICA.**IM Agency**— End Community Waiver Medicaid eligibility, if appropriate, upon receipt of this form.**ADRC or Tribal ADRS**— Staff are expected to perform disenrollment counseling for Section B, D and F disenrollments. Disenrollment counseling for Section C and E disenrollments may be done at the discretion of the ADRC or Tribal ADRS. Enter disenrollment into ForwardHealth (except for Section D or Section F disenrollment) upon receipt of form from the MCO or ICA. |

Distribution of completed form:

[ ]  BQO; [ ]  MCO; [ ]  Partnership organization; [ ]  PACE organization;

[ ]  ICA; [ ]  ADRC; [ ]  IM; [ ]  Tribe