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| **STATE OF WISCONSIN**  **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-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 organization  Note: 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