NC MEDICAID
Long Term Services and Supports (LTSS)
MANAGED CARE DISENROLLMENT FORM

DISENROLLMENT / RETURNING TO MEDICAID DIRECT REASON: (select one)	DISENROLLMENT DATE ON THE 834 or if due to CAP, POC Date:
☐ Becoming Dually Eligible ☐ Extended Nursing Home Stay ☐ CAP Enrollment (CAP/DA or CAP/C) ☐ Other: _____	_____/_____/_____

If selecting other as the Disenrollment Reason, please attach information to explain the reason in detail.

SECTION A. MEMBER DEMOGRAPHICS

Member's Name: First: _____ MI: _____ Last: _____ **DOB:** ____/____/____

Medicaid ID#: _____ **Medicare ID#:** _____

PASRR#: _____ **PASRR Start Date:** ____/____/_____ **PASRR Expiration Date if applicable:** ___/___/_____

RS-ID# (ACH Only) : _____ **RS-ID Date:** ____/____/_____

Gender: ☐ Male ☐ Female **Language:** ☐ English ☐ Spanish ☐ Other_____

Address: _____ **City:** _____

County: _____ **Zip:** _____ **Phone:** (___) _____

Plan Name (Select One): ☐ AmeriHealth Caritas ☐ Carolina Complete Health ☐ BCBS – Healthy Blue
☐ United Health Group ☐ WellCare ☐ Alliance Health ☐ Sandhills Center
☐ Eastpointe ☐ Vaya Health ☐ Trillium ☐ Partners Health Management

Enrollment Date: ____/_____/_____ Disenrollment Effective Date: _____/_____/_____

Member currently resides: ☐ Private Residence ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility
☐ Group Home ☐ Family Care Home ☐ Special Care Unit (ACH/SCU) ☐ Other_____

SECTION B. MEMBER'S CURRENT SERVICE PROFILE – LTSS Disenrollment forms are required for members currently receiving LTSS services in Managed Care, or members disenrolling from Managed Care due to CAP/DA or CAP/C enrollment. If neither scenario applies, a LTSS Disenrollment form is not required.

Identify the LTSS services currently received, service provider information and primary diagnosis of current **condition related to the member's need for LTSS.** Complete **ALL** information for each LTSS service received by member.

If member is not returning to Medicaid Direct, or if there are no current LTSS services, a LTSS Disenrollment Form is not necessary.

LTSS State Plan Service List	Provider Name & NPI	Primary Diagnosis ICD-10 Code	Currently Authorized Units (#)	Date of PA Authorization (mm/yyyy)
Home Health ☐	Name: _____ NPI: _____	_ _ _._ _ _ _		
Home Infusion Therapy (HIT) ☐	Name: _____ NPI: _____	_ _ _._ _ _ _		
Hospice ☐	Name: _____ NPI: _____	_ _ _._ _ _ _		
Private Duty Nursing for Members Under 21 Years of Age ☐	Name: _____ NPI: _____	_ _ _._ _ _ _		
Private Duty Nursing for Member Aged 21 and Above ☐	Name: _____ NPI: _____	_ _ _._ _ _ _		
State Plan Personal Care Services (PCS) ☐	Name: _____ NPI: _____	_ _ _._ _ _ _		
Skilled Nursing Facilities ☐	Name: _____ NPI: _____			

Other Value Added or In Lieu Of Services ☐	*List Services:*

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SECTION C. MEMBER'S NURSING HOME ALTERNATIVE CARE SETTING OPTIONS:

This section to be completed for members currently residing in a nursing facility.

Has member received Options Counseling? Yes ☐ **Date:**_____ **(attach summary)**
No ☐ **Reason:**_____

Check programs for which transition options been explored on member's behalf:

Transitions for Community Living (TCLI) ☐
Money Follows the Person (MFP) ☐
Transition to Adult Care Homes (ACH) ☐
Transition to Program for All-Inclusive Care for the Elderly (PACE) ☐
Community Alternatives Program for Children (CAP/C) ☐ Is member on wait list? Yes ☐ * No ☐
Community Alternatives Program for Disabled Adults (CAP/DA) ☐ Is member on wait list? Yes ☐ * No ☐

* *If Member is on any waitlist, please indicate their place on the list by providing a waitlist number if known:* _____

SECTION D. ATTESTATION

Care Manager Signature AND Credentials: _____ Date ___/_____/____

Signature stamp not allowed

Printed Name: _____

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."

Other comments to share with DHB about this individual: