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 Proposed Effective Date:**
☐ **Becoming Dually Eligible** ☐ **Extended Nursing Home Stay** ☐ **CAP Pending 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 ☐ Partners Health Management

☐ CFSP ☐ Vaya Health ☐ Trillium

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 ☐	*If yes, list services:*
Were PCS hours authorized more than the DHB policy limit? ☐	*If yes, list services, number hours/units approved, duration of the approval and reason for the approval.*

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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 have been explored on members' 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: