

FIDA Safe Discharge Disenrollment Confirmation



0000000000BK

Submit this form to your current plan if you want to leave your current plan and not join another FIDA Plan or other Managed Long-Term Care (MLTC) Plan.

Section 1. PLAN INFORMATION

Plan you want to leave: _____

Section 2. YOUR INFORMATION

Last Name First Name Middle Initial
____/____/____ Male Female ()____-____-____
Date of Birth Gender Area Code Telephone Number

Benefit ID Medicare Number
(located on your white, red and blue Medicare Card)

Permanent Address City State Zip Code

AUTHORIZED REPRESENTATIVE

Last Name First Name Middle Initial

Relationship to Applicant ()____-____-____
Area Code Telephone Number

Address City State Zip Code

Section 3. REASON FOR DISENROLLMENT

Please tell us the reason you want to leave your current plan and the reason you do not want to join another FIDA plan or other Managed Long Term Care plan.



0000000000BK

Section 4. YOUR SIGNATURE

Please read the following information and SIGN this document below:

I understand that by signing this form I am disenrolling from the Plan listed at the top of this form and not enrolling in another FIDA plan or other Managed Long Term Care plan. This means I might not be able to receive home care, adult day health care and other long-term care services. It also means the doctors and other health care providers I see now might not see me anymore. I will be notified if and when I am no longer in the Plan.

Sign Here ▶▶

Your Signature

Date

Authorized Representative's Signature

Date

Section 5. FIDA PLAN REPRESENTATIVE

Check the box if disenrollment was requested verbally.

- Verbal consent received from client requesting to be disenrolled from the current FIDA Health Plan, not enrolling into another FIDA Plan or MLTC Plan, and not eligible to receive LTSS from Medicaid FFS.

Verbal Consent received on: _____
Date

By signing this form, I confirm that the participant listed above has been provided with a safe plan of discharge and is able to remain safely in the community without the services that were being provided to the Participant by the FIDA Program.

Plan Representative Name (Please print)

Title

Signature

Date