

FIDA Safe Discharge Confirmation Form

Barcode

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	Date of Birth (mm/dd/yyyy)
Benefit ID	<input type="checkbox"/> Male <input type="checkbox"/> Female	Medicare Number (located on your red, white, and blue Medicare Card)		Telephone Number () Area Code	
Permanent Address			City	State	Zip Code

AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Last Name		First Name		Middle Initial	Relationship to Applicant
Address		City	State	Zip Code	Telephone Number () Area

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.

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.

If you need help understanding this form or if you have questions about your rights, please call Independent Consumer Advocacy Network (ICAN) or New York Medicaid Choice (NYMC) at the phone numbers below.

Sign Here ▶

Your signature

Date

Authorized representative signature

Date

Section 5. FIDA plan representative

Check the box below 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.

Sign Here ▶

Signature

Date

If you need help understanding this form or if you have questions about your rights, please call Independent Consumer Advocacy Network (ICAN) or New York Medicaid Choice (NYMC at the phone numbers below:

New York Medicaid Choice

For questions about the FIDA program and your Medicaid benefits

Call: 1-855-600-3432
TTY users: 1-888-329-1541
A free interpreter: 1-855-600-3432

Monday-Friday, 8:30 am – 8:00 pm
Saturday, 10:00 am – 6:00 pm

The call and the help are free.

Website: www.nymedicaidchoice.com

Independent Consumer Advocacy Network (ICAN)

For questions about your rights

Call: 1-844-614-8800
TTY users: 711
A free interpreter: 1-844-614-8800

Monday-Friday, 8:00 am – 8:00 pm

The call and the help are free.

Website: www.icannys.org