[Date]

YOUR REQUEST FOR VOLUNTARY WITHDRAWAL FROM HOME AND COMMUNITY-BASED SERVICES

By signing this form, you are confirming that you want to voluntarily withdrawal from Home and Community Based Services (HCBS) provided through the Community HealthChoices (CHC) Waiver.

[CHC-MCO] will notify the County Assistance Office (CAO) to take action to terminate your HCBS. You will receive a separate notice from the CAO. That notice will tell you how to appeal the decision to terminate your HCBS.

Your CHC HCBS Waiver service plan includes the following services:

1. **[Service]** **[Provider]**
2. **[Service]** **[Provider]**
3. **[Service]** **[Provider]**
4. **[Service]** **[Provider]**
5. **[Service]** **[Provider]**
6. **[Service]** **[Provider]**

[add more lines as needed]

Your signature below means that you understand that the services listed above will end.

Your signature also means that you understand that your eligibility for Medical Assistance may be impacted by your voluntary withdrawal from CHC HCBS.

________________________________ ________________

Participant Signature Date

________________________________ ________________

Service Coordinator Signature Date

________________________________ ________________

Witness Signature Date