| **WITHDRAWAL FROM THE COMMUNITY AND EMPLOYMENT SUPPORTS (CES)** **MEDICAID WAIVER PROGRAM** |
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| Name of individual |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **WAIVER PROGRAM PARTICIPANTS:** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [ ]  I hereby request that Developmental Disabilities Services close Medicaid Waiver services for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Services through the DDS CES Waiver Program are no longer wanted. My reason (s) for withdrawal is (are): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **WAIVER REQUEST LIST PARTICIPANTS:** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [ ]  I hereby request that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ be removed from the Developmental Disabilities’ CES Waiver Program Request List. I am not interested in receiving waiver services at this time. I understand that if I desire to have consideration for services through this Program in the future, I will have to complete a new CES-102 Choice form for services. I understand that consideration for services is based on the date the new request is made. My reason (s) for withdrawal from the Request List is (are) as follows: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **WAIVER APPLICANT IN PROGRESS LIST:** |
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| [ ]  I hereby request that the initial waiver application process for services through the Developmental Disabilities' CES Waiver Program for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ be stopped. I am not interested in receiving waiver services at this time. I understand that if I desire to have consideration for services through this Program in the future, I will have to complete a new CES-102 Choice form for services. I understand that consideration for services is based on the date the new request is made. My reason(s) for having the waiver application process for services stopped is (are) as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| [ ]  My appeal rights have been explained to me and I am aware that voluntary withdrawal means appeal rights are forfeited. |
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| I do [ ]  do not [ ]  want the 90 day transition period before my Waiver services close. |
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| Signature of Individual |  |  |  |  |  | Date |  |  |  |  |  |
|  |  |  |  |  |  |       |  |  |  |  |  |
| Signature of Parent/Legal Representative |  |  |  |  |  | Date |  |  |  |  |  |
|  |  |  |  |  |  |       |  |  |  |  |  |
| Signature of Witness |  |  |  |  |  | Date |  |  |  |  |  |
|  |  |  |  |  |  |       |  |  |  |  |  |
| Signature of DDS Representative |  |  |  |  |  | Date |  |  |  |  |  |