

## STEPS Voluntary Disenrollment Form

Member Name: \_\_\_\_\_

Guardian or STEPS Representative Name: \_\_\_\_\_

Reason for disenrollment:

Check one of the below:

- I wish to remain in Working Healthy without STEPS services. (Must meet all other WH criteria)
- I wish to return to HCBS waiver or wait list I came from, if applicable.
- I wish to leave Working Healthy / STEPS and do not have a waiver or waitlist to return to.

HCBS / STEPS Safety net:

- \* I understand that if I was on an HCBS waiver the month prior to starting STEPS I can return to that waiver if I am not over resources and have not had a gap in HCBS / STEPS services.
- \* I understand that if I was on an HCBS wait list the month prior to starting STEPS or if I was added to a wait list while in STEPS, I will remain on that wait list as per my waitlist date, or until I am offered a waiver spot.

Working Healthy Benefit Specialist:

If I have questions about my benefits and the impact leaving STEPS services may have on my benefits, I can contact my Working Healthy Benefit Specialist (WHBS).

- I plan to contact my Working Healthy Benefit Specialist.
- I do not plan to contact my Working Healthy Benefit Specialist.

**All closures go into effect the last day of the month.**

**If there will be a transition to an HCBS Waiver, the STEPS Program Manager MUST be notified BEFORE the 18<sup>th</sup> of the month and the participant MUST speak with the WHBS.**

Date of this request: \_\_\_\_\_

Date of Closure: \_\_\_\_\_

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian or STEPS Representative Signature (If applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
CSC or MCO Signature

\_\_\_\_\_  
Date