GOVERNMENT OF THE
DISTRICT OF COLUMBIA
DEPT OF HEALTH CARE FINANCE
LONG-TERM CARE ADMINISTRATION

Services My Way

VOLUNTARY PARTICIPANT TERMINATION NOTICE

Date: _____ (MM/DD/YY)

Participant Name: _____

Medicaid Number: _____

Effective Date of Termination: _____

Reason for Termination: _____

_____

Name of Person Submitting Notice: _____

Street Address: _____

City/State/Zip: _____

Telephone #: _____ **Email Address:** _____

Relationship to Participant: _____

This Termination Notice must be submitted to the Vendor Fiscal/Employer Agents (F/EA) Financial Management Service (FMS)-Support Broker entity within 48 hours of date/reason for termination.

_____ _____
Signature of Person Submitting Notice *Date*

_____ _____
Signature of Support Broker *Date*

_____ _____
Signature of the Services My Way Program Coordinator *Date*