DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10142 (07/08)

STATE OF WISCONSIN

INTERAGENCY NOTIFICATION OF TERMINATION OF MEDICAID WAIVER ELIGIBILITY FOR A COMMUNITY WAIVER PARTICIPANT

This form is to be filled out by the Income Maintenance worker and sent to the Care Manager/Support and Services Coordinator when the Medicaid Waiver participant loses Medicaid Waiver eligibility.

Name - Community Waiver Care Manager / Support and Services Coordinator
Name – Income Maintenance Worker
Name - Waiver Participant

Case Number	Social Security Number
Medicaid Waiver Termination Date	
Reason for Termination	
Additional Comments	

SIGNATURE - IM	Date Sent
SIGNATURE – CM / SSC	Date Received

RESET FORM