DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-22637 (03/2017)

STATE OF WISCONSIN
42 CFR 431

INTERAGENCY NOTIFICATION
TERMINATION OF COMMUNITY WAIVER PARTICIPATION

This form is to be completed by the care manager/support and service coordinator and sent to the Income Maintenance Worker (IMW) when the community waiver participant loses Medicaid community waiver eligibility.

NAME – Community Waiver Care Manager/Support and Service Coordinator	Agency
NAME – Income Maintenance Worker	County
NAME – Community Waiver Participant	
Case / ID Number	Social Security Number (Optional)

Reason for Termination

- ☐ No longer meets functional/level of care eligibility
- ☐ No longer resides in eligible living arrangement[1]
- ☐ Failed to meet post-eligibility requirements (ISP not signed, cost share payment(s) not made, spenddown not met, etc.)
- ☐ Participant has notified the agency of his/her decision to discontinue program participation
- ☐ Other—Specify: ____________________

Additional Comments

Date Sent to IMW	**SIGNATURE** – CM/S&SC
Date Received by IMW	**SIGNATURE** - IMW

[1] When a waiver participant moves to an ineligible living arrangement, the action of termination of waiver services may be initiated without advance notice (42 CFR 431.213 (c)). This means that the LTSA notice can give an effective termination date shorter than the normally required 10 days. Note that care managers still need to notify the ESA that waiver services are being terminated.