



State of Missouri
 Department of Mental Health
 Division of Developmental Disabilities
Provider Disenrollment Form for Southeast Missouri Autism Project Services

Individual Name	Date of Birth
Medicaid Number	DMH ID Number
End Date of Autism Project Provider(s) Services	
Reason for ending DD Autism Project Services: <input type="checkbox"/> Individual enrolled in a Medicaid Waiver (support coordinator signature required below) <input type="checkbox"/> Individual discharged from the Division of Developmental Disabilities (support coordinator signature required below) <input type="checkbox"/> Individual declined to continue receiving services funded through Southeast Missouri Autism Project (Individual/Parent/Guardian/Designated Representative and support coordinator signatures required below) <input type="checkbox"/> Individual discharged by provider (support coordinator signature required below) <input type="checkbox"/> Individual transferred to a region where the Autism Project business model does not offer similar Services (support coordinator signature required below)	
Providers authorized to provide autism project services (check all that apply) that will be removing individual from their rolls and concluding service provision: <input type="checkbox"/> Easter Seals Midwest Life Skills <input type="checkbox"/> Southeast Missouri State University Autism Center <input type="checkbox"/> Blue Sky Community Services	
Individual/Parent/Guardian/Designated Representative Certification and Signature(s) Section	
Individual	Date
Parent/Guardian/Designated Representative	Date
Support Coordinator Certification and Signature Section	
I certify that the family has been informed that authorizations for Autism Project services will be discontinued. I certify that the family has been informed that (unless grandfathered) enrollment in a Medicaid Waiver prohibits receiving Autism Project services.	
Name of Support Coordinator and TCM or Regional Office affiliation (please print name legibly):	
Email	Phone
Support Coordinator Signature	Date

This form is intended to facilitate communication among the family, Regional Office, the Targeted Case Management Entity, and Autism Project Providers to ensure proper protocols are being followed. Autism Project authorizations will be discontinued via this disenrollment. **Distribute copies to** Individual/Parent/Guardian/Designated Representative, Provider(s), and Regional Office Utilization Review Lead.