



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	
<b>Reason for ending DD Autism Project Services:</b> <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)	
<b>Providers authorized to provide autism project services (check all that apply) that will be removing individual from their rolls and concluding service provision:</b> <input type="checkbox"/> Easter Seals Midwest <input type="checkbox"/> Southeast Missouri State University Autism Center <input type="checkbox"/> Blue Sky Community Services	
<b>Individual/Parent/Guardian/Designated Representative Certification and Signature(s) Section</b>	
Individual	Date
Parent/Guardian/Designated Representative	Date
<b>Support Coordinator Certification and Signature Section</b>	
I certify that the family has been informed that authorizations for Autism Project services will be discontinued.	
Name of Support Coordinator and TCM or Regional Office affiliation <b>(please print name legibly):</b>	
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.