State of Missouri
Department of Mental Health
Division of Developmental Disabilities
Provider Disenrollment Form for Southwest 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 Program:

☐ Individual discharged from the Division of Developmental Disabilities (support coordinator signature required below)
☐ Individual declined to continue receiving services funded through Southwest Missouri Autism Project (Individual/Parent/Guardian/Designated Representative and support coordinator signatures required below)
☐ Individual discharged by provider (support coordinator signature required below)
☐ 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 program services (check all that apply) that will be removing individual from their rolls and concluding service provision:

☐ Abilities First (Art Inspired Academy)
☐ Alternative Opportunities
☐ Arc of the Ozarks - Counterpoint
☐ Burrell Autism Center
☐ Judevine Center for Autism
☐ Easter Seals Midwest
☐ Ozark Center | Bill & Virginia Leffen Center for Autism

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.

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.