



**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.