

**DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES**

**WITHDRAWAL FROM THE ALTERNATIVE COMMUNITY SERVICES (ACS)
MEDICAID WAIVER PROGRAM**

Name of individual _____

WAIVER PROGRAM PARTICIPANTS:

I hereby request that Developmental Disabilities Services close Medicaid Waiver services for _____ Services through the DDS ACS Waiver Program are no longer wanted. My reason (s) for withdrawal is (are): _____

WAIVER REQUEST LIST PARTICIPANTS:

I hereby request that _____ be removed from the Developmental Disabilities' ACS Waiver Program Request List. I am not interested in receiving waiver services at this time. I understand that if I desire to have consideration for services through this Program in the future, I will have to complete a new ACS 102 Choice form for services. I understand that consideration for services is based on the date the new request is made. My reason (s) for withdrawal from the Request List is (are) as follows: _____

WAIVER APPLICANT IN PROGRESS LIST:

I hereby request that the initial waiver application process for services through the Developmental Disabilities' ACS Waiver Program for _____ be stopped. I am not interested in receiving waiver services at this time. I understand that if I desire to have consideration for services through this Program in the future, I will have to complete a new ACS 102 Choice form for services. I understand that consideration for services is based on the date the new request is made. My reason(s) for having the waiver application process for services stopped is (are) as follows: _____

My appeal rights have been explained to me and I am aware that voluntary withdrawal means appeal rights are forfeited.

I do do not want the 90 day transition period before my Waiver services close.

Signature of Individual

Date

Signature of Parent/Legal Representative

Date

Signature of Witness

Date

Signature of DDS Representative

Date