| **WITHDRAWAL FROM THE COMMUNITY AND EMPLOYMENT SUPPORTS (CES)**  **MEDICAID WAIVER PROGRAM** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of individual | | | | | | |  | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **WAIVER PROGRAM PARTICIPANTS:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| I hereby request that Developmental Disabilities Services close Medicaid Waiver services for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Services through the DDS CES Waiver Program are no longer wanted. My reason (s) for withdrawal is (are): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **WAIVER REQUEST LIST PARTICIPANTS:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| I hereby request that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ be removed from the Developmental Disabilities’ CES 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 CES-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: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **WAIVER APPLICANT IN PROGRESS LIST:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| I hereby request that the initial waiver application process for services through the Developmental Disabilities' CES 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 CES-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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| My appeal rights have been explained to me and I am aware that voluntary withdrawal means appeal rights are forfeited. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| I do  do not  want the 90 day transition period before my Waiver services close. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Signature of Individual | | | | | | | | | | | | | | | | |  |  |  |  |  | Date | | | | | | | | |  |  |  |  |  |
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| Signature of Parent/Legal Representative | | | | | | | | | | | | | | | | |  |  |  |  |  | Date | | | | | | | | |  |  |  |  |  |
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| Signature of Witness | | | | | | | | | | | | | | | | |  |  |  |  |  | Date | | | | | | | | |  |  |  |  |  |
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| Signature of DDS Representative | | | | | | | | | | | | | | | | |  |  |  |  |  | Date | | | | | | | | |  |  |  |  |  |