STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE
HCBS VOLUNTARY TERMINATION REQUEST

SECTION 1: PROVIDER INFORMATION – COMPLETE ALL APPLICABLE FIELDS IN A LEGIBLE MANNER. Please complete ONE form per provider EIN. **THIS IS A REQUIRED SECTION.**

LEGAL AGENCY NAME AS IT APPEARS WITH THE IRS:					
DOING BUSINESS AS NAME (IF APPLICABLE):					
EMAIL ADDRESS FOR CONFIRMATION OF CHANGES:					
NPI (REQUIRED):			SSBG (optional):		
☐ CDS	☐ In-Home Services (IHS)	☐ Reassessments	☐ Adult Day Care	☐ RCF (Residential Care)	☐ ALF (Assisted Living)

SECTION 2: VOLUNTARILY TERMINATION DATE – Effective Date Must Be Consistent On All Documents Submitted.

I WISH TO VOLUNTARILY TERMINATE MY ENROLLMENT WITH MOHEALTHNET EFFECTIVE – (MM/DD/YYYY): ____________________________

SECTION 3: THE FOLLOWING MUST BE ATTACHED – Use the checkboxes to check off documents as you go to ensure you have all items necessary to process your request

☐	Letter of Intent to Voluntarily Terminate the enrollment – addressed to **Missouri Medicaid Audit and Compliance**, including the effective date of termination.
☐	Letter of intent to Voluntarily Terminate the enrollment – addressed to **Dept of Heath and Senior Services**, including the effective date of termination.
☐	Letter to all **Missouri Medicaid participants** currently enrolled with your facility – listing the date of closing **OR** A letter to Missouri Medicaid Audit and Compliance indicating there are **no participants** receiving services through your entity.
☐	List of Participants' names and DCN's that you are currently providing services to – if applicable.
	If being purchased by another enrolled entity include:
☐	Asset Purchase Agreement
☐	An additional document listing the entity's name, as well a direct contact person and phone

SECTION 4: LOCATION WHERE RECORDS WILL BE KEPT OR STORED FOR 6 YEARS AFTER THE TERMINATION DATE ABOVE:

Address:	City:	State:	Zip:
Future contact person name and title:			
Future contact phone:			
Future contact e-mail:			

THE AUTHORIZED SIGNER OF THIS DOCUMENT VERIFIES THAT HE/SHE IS AN INDIVIDUAL OR THE REPRESENTATIVE OF THE PROVIDER/VENDOR AND IS THE DULY AUTHORIZED AGENT TO EXECUTE THIS CHANGE REQUEST DOCUMENT ON BEHALF OF THE PROVIDER/VENDOR UNDER AUTHORITY GRANTED BY SAID PROVIDER/VENDOR.

(Original Signature) **Electronic signature is not acceptable**	**Date:**
TYPE OR PRINT NAME OF AUTHORIZED PERSON SIGNING:	**TITLE OF AUTHORIZED SIGNER:**

PLEASE FAX FORM & ALL DOCUMENTS TO 573-634-3105. DO NOT EMAIL FORM Unless Instructed. ALL OF THE REQUIRED DOCUMENTATION MUST BE SUBMITTED TO PROCESS YOUR REQUEST.

MISSOURI MEDICAID AUDIT AND COMPLIANCE USE ONLY BELOW:

☐ APPROVED ☐ REJECTED – REASON ATTACHED.	SENT TO: ☐ DHSS ☐ TERMINATIONS ☐ OTHER:
MMAC STAFF ID/SIGNATURE:	**DATE:**