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ODMR/DD Notification of Individual Change in Status (NICs)

Waiver Recipient's Name:		
First Name:	Last Name:	County:
MR/DD Resident #:	SSN:	Waiver #:
Current Waiver Type: ☐ Level 1 ☐ I/O	**LOC DATE:**	

SECTION 1 - CHANGE OF NAME

Waiver Recipient's Former Name:		Waiver Recipient's New Name:	
First Name:	Last Name:	First Name:	Last Name:

SECTION 2 – COUNTY TO COUNTY TRANSFER

Waiver Funding County:	County to Administer Waiver:	Residence County:	Transfer Effective Date:
Date New County Notified:		Date ODJFS Notified:	

SECTION 3: TEMPORARY SUSPENSION OF WAIVER SERVICES

Note: Recipient may be disenrolled after 90 days.

SECTION 3a: TEMPORARY SUSPENSION Complete this section as soon as it is determined that a waiver recipient needs to be suspended due to admission to a non-waiver facility or "Other" stated reason.	**Last date of waiver services:**	
Reason for Suspension: ☐ Hospital ☐ Nursing Facility ☐ ICF/MR ☐ Jail/Prison ☐ Other: (explain)	Complete if Applicable:	
	Admission Date:	
	Facility Name:	
	Facility Address:	

SECTION 3b: FACILITY TRANSFER: Complete this section if the recipient has been transferred from one facility to another. (For example: from a Hospital to a NF or from a NF to a Rehab Center etc.)	Discharge date from previous facility:	
	Admission date to new facility:	
New Facility: ☐ Hospital ☐ Nursing Facility ☐ ICF/MR ☐ Jail/Prison ☐ Other: (explain)	Complete if Applicable:	
	Admission Date:	
	Facility Name:	
	Facility Address	

SECTION 3c: RESTART OF SERVICES : Complete this section if recipient has been permanently discharged from a non-waiver facility and/or waiver services have restarted. Waiver restart date may vary from date provided based on discharge verification from ODJFS. Waiver restart date will be the day after discharge date.	**Last date of waiver services:**	
	Discharge date from facility:	
	Waiver Restart Date:	

Completed by:	**Phone #:**	**Ext.**	**Date:**

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Waiver Recipient's Name:		
First Name:	Last Name:	County:
MR/DD Resident #:	SSN:	Waiver #:
Current Waiver Type: ☐ Level One ☐ I/O	**LOC DATE:**	

SECTION 4 - DISENROLLMENT/WITHDRAWAL FROM WAIVER PROGRAM

Note:

1. **Submit required PAWS documents to complete all actions on this page.**
2. **Recipient or guardian signatures are required for all disenrollments, withdrawals and Change of Waiver Type, except death.**
3. **Please select "Reason" that best describes recipient's status. Such as, if recipient will be a permanent resident of an IFC/MR, check "ICF/MR" as well as "Voluntary".**
4. **If reason for "Voluntary" disenrollment is not listed, please explain in space provided.**

Reason:	☐ **Death**	Last Date of Waiver Services:	
☐ Hospital ☐ Nursing Facility ☐ ICF/MR ☐ Jail/Prison ☐ Moved Out of State ☐ Withdrawal of Initial Application ☐ Voluntary (explain below) ☐ Other: (explain below)	**Date of Death:** **Place of Death:** ☐ Hospital ☐ Nursing Facility ☐ Home ☐ Other: (explain below)	Complete if Applicable: Admission Date: Facility Name: Facility Address or mailing address if different:	

☐ **CHANGE OF WAIVER TYPE**

Note: **Submit new initial application packet with the NICs.**

Current Waiver:	☐ Level One	☐ I/O	**New Waiver:**	☐ Level One	☐ I/O
Waiver #			Waiver #		
Last Date of Waiver Services:			Date Waiver Services to Begin:		

I _____, (enrollee/applicant, or legal guardian) for _____ (enrollee/applicant), do hereby request the Ohio Department of Mental Retardation and Developmental Disabilities to discontinue the enrollment or the pursuit of enrollment as noted above in this document.

Enrollee/Applicant Signature — **Signature Date**

Legal Guardian Signature — **Signature Date**

Completed by:	**Phone #:**	**Ext.**	**Date:**

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