



County

VOLUNTARY WITHDRAWAL REQUEST

Member Name			
	<i>Last</i>	<i>First</i>	<i>Middle</i>
Address			
	<i>Street</i>	<i>City</i>	<i>State</i> <i>Zip</i>
Medicaid #			

A. WITHDRAWAL REQUEST	
Case Management Agency	
Case Manager	
<p>I request my application to the ADvantage Program be withdrawn.</p> <p><input type="checkbox"/> I request termination of all ADvantage Program services.</p> <p><input type="checkbox"/> I have been informed that I may re-apply at any time.</p> <p><input type="checkbox"/> I request referral to the following services:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>Reason for withdrawal</p> 	

Signature of Member or Legal Agent <small>(If Consumer signs with mark, two witnesses are required)</small>	Date
Signature of Witness	Date
Signature of Case Manager	Date