Arizona Department of Economic Security
Division of Developmental Disabilities

Voluntary Withdrawal Form

Member: _____

Date of Birth: _____ Date: _____

AHCCCS ID: _____

Assist ID: _____

The reason for withdrawal:

Effective Date: _____

Request to withdrawal from:

☐ Division of Developmental Disabilities Only
(Division funded or Targeted Support Coordination Only Members)

☐ Division of Developmental Disabilities & AHCCCS Long-term care Services and Supports (ALTCS)

☐ Please discontinue my benefits immediately. Check this if you are moving and plan to apply for Medicaid services in another state. I understand I will not receive a notice before my benefits stop.

See page 2 for EOE/ADA disclosures

I understand that this action does not affect my right to apply for benefits in the future. If member is enrolled in Arizona Long Term Care Services (ALTCS), the Division cannot close the case until AHCCCS/ ALTCS disenrollment has been completed.

Member Signature: _____

Date: _____

Legal Guardian Signature: _____

Date: _____