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.

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: _____