DEPARTMENT OF HEALTH AND HOSPITALS
Aging and Adult Services

Declining Current Adult Day Health Care (ADHC) Waiver Services

Date: ______________________________

I, ________________________________, understand that I am currently receiving the Adult Day Health Care (ADHC) Waiver services. I have chosen to stop receiving ADHC Waiver services effective immediately.

I understand that my ADHC Waiver case will be closed and I will no longer get ADHC Waiver services. I also understand that I may lose my Medicaid eligibility.

In the future, if I want to get ADHC Waiver services, I will need to have my name added back to the ADHC Waiver Request for Services Registry (RFSR), by calling Louisiana Options in Long Term Care at 1-877-456-1146.

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Name of Participant (Please print.)

________________________________ ________________________
Participant's Last 4 Digits of Social Security Number Date of Birth

________________________________ ________________________
Signature of Participant Date

________________________________ ________________________
Signature of Responsible Representative (if applicable) Date

________________________________ ________________________
Signature of OAAS Representative Date