

Veteran's Directed Program  
**Enrollment/Disenrollment Form**



*(first section completed by the AAA Care Advisor)*

Care Advisor \_\_\_\_\_ AAA \_\_\_\_\_

Participant Demographic Information			
Last Name		First Name	
Residential Address	City	County	Zip
Mailing Address	City	County	Zip
Home Phone	Cell Phone	ID # (Last 4 SS#)	Date of Birth
Is Participant using a Representative? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Representative's Name			
Home Phone Number	Cell Phone	Work Phone	

Enrollment Information	
Eligibility Date: _____	Assessment/Enrollment Date: _____
Service Connected Disability: _____%	ICD10 Code: _____
Current VA-HCBS:	

Approved Budget			
Tier / Budget	Approved Budget Amount	Approved by	Date
_____/_____	\$_____ - _____ = \$_____		

Disenrollment Information	
Disenrollment Date	
Reason for Disenrollment	
<input type="checkbox"/> No longer need/want services <input type="checkbox"/> Moved to Private Care Home <input type="checkbox"/> Moved to NH/Residential Care <input type="checkbox"/> Relocated out of area <input type="checkbox"/> Other: _____	<input type="checkbox"/> Improved functional status <input type="checkbox"/> Not able to effectively manage/direct service plan <input type="checkbox"/> Deceased <input type="checkbox"/> Hospitalized for 15 or more days
If Participant moved to LTC Facility, please indicate the reason for facility placement (check all that apply):	
<input type="checkbox"/> Fall/acute medical need <input type="checkbox"/> Personal care needs cannot be met at home <input type="checkbox"/> Behavior care needs	<input type="checkbox"/> Caregiver has health problems <input type="checkbox"/> Caregiver has other responsibilities <input type="checkbox"/> Other: _____

To be signed upon disenrollment:

Care Advisor: \_\_\_\_\_

Date: \_\_\_\_\_

Participant/Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_