MLTSS Community Supports (CS) Disenrollment Notification

Disenrollment Request (select one):

☐ **Attn: L.A. Care MLTSS Dept. - Member is no longer receiving services. Please end date authorization.**

☐ **Attn: CS Provider - Member no longer needs services. Please discontinue services.**

Member Information

Member ID (CIN #):

Member Name (Last Name, First Name):

Member DOB (MM/DD/YYYY):

Authorization Number:

CS Program:

Disenrollment Information:

- ✓ Reason for disenrollment:
  - ☐ IHSS in place
  - ☐ Backup caregiver in place
  - ☐ No longer needs services
  - ☐ Member no longer interested in services
  - ☐ No longer eligible with L.A. Care Health Plan
  - ☐ Expired Date of death: Notified by:
- ✓ Last date services rendered: _____
- ✓ Additional comments:

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Please fax this notification to Fax # 213-985-1835
If you have any questions, please contact:
MLTSS: 1-855-427-1223 or mltss@lacare.org