

VOLUNTARY TERMINATION OF MEDICAID PROVIDER AGREEMENT

(Submit this form **only** if you want to end your provider agreement)

Date: _____

To: ODJFS ~ Bureau of Long-Term Care Services & Supports

From: Provider #: _____

Provider

Name: _____

(please print clearly)

Address:

I, (print your name) _____, am voluntarily relinquishing my independent provider number and request that my provider agreement be terminated effective the date of this notice. I no longer provide services to consumers on the Ohio Home Care Waiver. I understand that if I voluntarily terminate my provider agreement I must reapply, and be accepted, before providing services in the future.

Signature

Date

If you are **voluntarily terminating** your provider agreement, return this form to:

**Ohio Department of Job & Family Services
Bureau of Long-Term Care Services & Supports**

**Attn: BCI Coordinator
P.O. Box 182709 5th Floor
Columbus, OH 43218-2709**

TELEPHONE: (614) 466-6742

FAX: (614) 466-6945