Member Name

Member Address

Member Address 2

City, State, Zip

[DATE OF LETTER]

Dear [MEMBER NAME],

This letter is to let you know that you are officially being disenrolled from the Health Home program at [CMA NAME]. Your case is being closed because [INSERT REASON].

This means that effective [CLOSURE DATE] all consents you signed for the program are no longer valid, active consents.

If you need help with care coordination in the future or would like any of the documents we completed together, please contact us at [PHONE NUMBER]. You can also contact any of the numbers below in you need help in the future.

|  |  |
| --- | --- |
| Community Health Connections, your Health Home at [CMA NAME] | 518-271-3301 |
| Your Managed Care Organization (MCO): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [MCO NUMBER] |
| New York State Medicaid Helpline | 800-541-2831 |
| New York State Medicaid Choice | 800-505-5678 |
| New York State Office of Temporary Disability Assistance (OTDA) | 518-473-1090 |

I have enjoyed working with you.

Sincerely,

CARE COORDINATOR NAME

Care Coordinator