

**Department of Health and Human Services
Office of Adult Mental Health Services
AGENCY REQUEST TO TERMINATE OR INTERRUPT SERVICES FORM**

Date _____

Consumer Information

Name _____ Guardian's Name _____

SSN _____

Address _____ Address _____

Phone # (Consumer's) _____ Phone# _____

(Message) _____

Services to Be Terminated _____ Interrupted _____ (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Community Integration | <input type="checkbox"/> Supported Housing/Residential/PNMI |
| <input type="checkbox"/> Intensive Community Integration | <input type="checkbox"/> Daily Living Support Services |
| <input type="checkbox"/> Intensive Case Management | <input type="checkbox"/> Skills Development Services |
| <input type="checkbox"/> ACT | <input type="checkbox"/> Day Supports Services |
| <input type="checkbox"/> Medication Management | <input type="checkbox"/> Vocational Services |
| <input type="checkbox"/> Outpatient Therapy | <input type="checkbox"/> Other _____ |

Agency Information

Agency Name _____ Phone # _____

Address _____

Please List Name of Worker and Service(s) to be Terminated/Interrupted

Worker's Name _____ Service _____ Phone# _____

Supervisor's Name _____ Title _____ Phone # _____

Worker's Name _____ Service _____ Phone# _____

Supervisor's Name _____ Title _____ Phone# _____

Worker's Name _____ Service _____ Phone# _____

Supervisor's Name _____ Title _____ Phone # _____

Please State Reason(s) for Request to Terminate/Interrupt Services (please explain)

Goals have been met _____

Consumer requesting termination _____

- Consumer relocated _____
- Consumer transferred to another agency _____
- Consumer not engaging in services _____
- Incarcerated for indefinite period _____
- Consumer poses a threat to worker/agency _____
- Consumer in residential facility/needs met _____
- Other _____

Is the consumer aware of the request to Terminate/Interrupt Services? Yes ___ No ___
Is Consumer is in Agreement? Yes ___ No ___ (please explain)

Agency consumer was referred to for CSW services: _____
New CSW name and date he/she is to begin services: _____
Other agencies/services consumer was referred to: _____

List other providers notified of your intent to terminate services: _____

Person Completing Form _____

Signature/Title

DHHS/OAMHS Response, Request (check all that apply):

- Approved
 - consumer concurs guardian concurs
 - consumer did not respond to letters/phone calls by date given by CDC
 - consumer responded to letters/phone calls and is asking for a new worker
 - followed up and confirmed with new agency that client has been picked up
 - other, please specify _____
- Denied
 - consumer disagrees with request Denied/guardian disagrees with Request
 - consumer responded to letters/phone calls and is asking for a new worker
 - followed up and confirmed with new agency that client has not been picked up

- though consumer no-showing/cancelling appointments, wants to stay with the agency
- consumer is incarcerated but not for an extended period
- other, please specify _____

Information informing decision to approve or deny request: _____

Date _____
CDC or Mental Health Team Leader Signature

**Consumer Must Be Given a Thirty Day Written Notice and
Copy of Written Notice Must Be Sent to the CDC Office**