ACCORD

Bringing Possibilities to Life

2004b. NOTICE OF SERVICE TERMINATION

Date [insert date of written notice]

Person/Legal Guardian
Address
City, State Zip

re: Service Termination
Name
DOB
PMI

Dear [the person receiving services or legal representative]:

This letter is notification of service termination for [name of person receiving services]. You are currently receiving _____ services funded by the following waiver program: __BI, __CAC, __CADI, __DD, __EW/AC.

The effective date of service termination is [date must be at least 30 days for basic support services and 60 days for intensive support services after the program has provided this written notice to the person, legal representative, and case manager].

The reason for the service termination:

____ The termination is necessary for your welfare and your needs cannot be met in this facility.

____ The safety of you or others in the program is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety of you or others.

____ The health of you or others in the program would otherwise be endangered.

____ This program has not been paid for services provided to you.

____ This program has not been paid for services.

____ This program ceases to operate.

____ You have been terminated by your county social service agency from waiver eligibility.

ACCORD

Bringing Possibilities to Life

Prior to giving this service termination notice, this program has at a minimum:

____ Consulted with your support team or expanded support team to identify and resolve issues leading up to the issuance of this notice.

____ Made a request to your case manager for intervention services or other professional consultation or intervention services to support you in this program.

This program has taken the following actions and/or measures to minimize or eliminate the need for proposed service termination:

The reason(s) why the actions and/or measures failed to prevent the proposed service termination:

You have the right to appeal this termination of services under Minnesota Statutes, section 256.045, subdivision 3, paragraph (a). See attached form – Request to Appeal a Service Termination.

You have the right to seek a temporary order preventing the termination of services according to procedures in Minnesota Statutes, section 256.045, subdivision 4a or 6, paragraph (c). See attached form – Request to Seek a Temporary Order Staying the Termination of Services.

During the service termination notice period, this program will

- work with your support team or expanded support team to develop reasonable alternatives to protect you and others and to support continuity of your care;
- provide information requested by you or your case manager; and
- maintain information about the service termination, including this notice, in your record.

_____ _____

Name/Title/Signature Date

Name of provider, address, phone number

Date mailed:	Name	Title
		Person
		Legal Representative

ACCORD

Bringing Possibilities to Life

	Name of Case Manager: County of Financial Responsibility: Case Manager Phone Number:	Case Manager
	Fax to 651-431-7406	DHS Commissioner (residential services only)

attachments

ACCORD

Bringing Possibilities to Life

REQUEST TO APPEAL A SERVICE TERMINATION

___ I wish to appeal the service termination notice that was provided to me.

I receive services from _____.
Their address is _____.
Their phone number is _____.
The date they provided me a service termination notice was _____.

I disagree with the action taken. I am appealing the proposed service termination because:

_____

_____

I wish to be contacted on further steps on the appeal process.

Contact Information	Name	Phone Number	Address
Person			
Legal Representative			

_____ _____
Person/Legal Representative Signature Date

SEND TO: Minnesota Department of Human Services
Appeals Office
PO Box 64941
St. Paul, MN 55164-0941

651-431-7523 (fax)

ACCORD

Bringing Possibilities to Life

REQUEST TO SEEK A TEMPORARY ORDER STAYING THE TERMINATION OF SERVICES

___ I wish to seek a temporary order to prevent the termination of my services.

I receive services from _____.
Their address is _____.
Their phone number is _____.
The date they provided me a service termination notice was _____.

I disagree with the action taken. I am seeking a temporary order staying the termination of my services because:

_____

_____

Contact Information	Name	Phone Number	Address
Person			
Legal Representative			

_____ _____
Person/Legal Representative Signature Date

SEND TO: County social service agency that is financially responsible for your services