# **Notice of Service Termination**

REQUIREMENTS FOR USE OF THIS SAMPLE DOCUMENT: 245D license holders are responsible for modifying this sample for use in their program. At a minimum, you must fill in the blanks on this form. You may modify the format and content to meet standards used by your program. This sample meets compliance with current licensing requirements as of August 1, 2022. Providers remain responsible for reading, understanding and ensuring that this document conforms to current licensing requirements. DELETE THIS HIGHLIGHTED SECTION TO BEGIN MODIFYING THIS FORM.

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 the license holder cannot meet your needs.

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

\_\_\_\_ The health of you, others in the program, or staff would otherwise be endangered.

\_\_\_\_ This license holder has not been paid for services provided to you.

\_\_\_\_ This program or the license holder ceases to operate.

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

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 termination 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 |
|  | 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

# **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)

# **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