Department of Health and Human Services
Office of Behavioral Health
AGENCY REQUEST TO TERMINATE OR INTERRUPT SERVICES

Date____________________

Client Information
Name_____________________________ Guardian's Name (if applicable)________________
DOB___________________________________

Address__________________________________ Address__________________________________
____ ____
____ ____

Phone # _______________________ Phone# __________________________________
(Message) ___________________________________

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

- □ Community Integration
- □ Intensive Community Integration
- □ Intensive Case Management
- □ ACT
- □ Medication Management
- □ Outpatient Therapy
- □ Supported Housing/Residential/PNMI
- □ Daily Living Support Services
- □ Skills Development Services
- □ Day Supports Services
- □ Vocational Services
- □ 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 #__________

Reason(s) for Request to Terminate/Interrupt Services (please describe)
□ Goals have been met ____
____
□ Client requesting termination ____
____

☐ Client relocated ____
____

☐ Client transferred to another agency ____
____

☐ Client not engaging in services ____
____

☐ Incarcerated for indefinite period ____
____

☐ Client poses a threat to worker/agency ____
____

☐ Client in residential facility/needs met ____
____

☐ Other ____
____

Is the Client aware of the request to Terminate/Interrupt Services? Yes ___ No ___
Is Client in Agreement? Yes_____ No_____ (please explain)

____
____
____
____
____

If applicable, agency Client was referred to for services:

____

New service name and start date: ____

Other agencies/services Client was referred to: _______________________________
____

Other providers notified of your intent to terminate services: ____________________
____
____

Person Completing Form:____

____
Signature/Title

DHHS/OBH Response (to be provided within 15 business days, check all that apply):

☐ Approved

- ☐ Client concurs ☐ guardian concurs
- ☐ Client did not respond to letters/phone calls by date given by OBH
- ☐ followed up and confirmed with new agency that client has been admitted for services
- ☐ Client repeatedly no-showing/cancelling appointments; provider has informed or has exhausted efforts to inform Client of intent to terminate and client has subsequently not kept appointment for 30 days or longer
- ☐ other, please specify ____
____

☐___ Denied

☐ Client disagrees with request ☐ Denied/guardian disagrees with request

☐ Client 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 Client no-showing/cancelling appointments, wants to stay with the agency and more than 30 days has not passed from provider communicating intent to terminate services

☐ Client is incarcerated, but not for an extended period

☐ other, please specify ____

____

Information informing decision to approve or deny request: ______________________________

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____ **Date**________________________

OBH Signature

Client Must Be Given a Thirty Day Written Notice and
Copy of Written Notice Must Be Sent to the OBH