



# DD HCBS CASE CLOSURE/TRANSFER NOTICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEVELOPMENTAL DISABILITIES/HCBS

SFN 1008 (2-2023)

Human Service Center Name	Developmental Disabilities Program Manager
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### Closure/Denial Section

Client Name (Last, First, Middle)	ID Number	Date of Closure	Closure Code
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### Closure Codes:

- B - Transferred to Basic Care
- C - Client Discontinued/Refused Service
- D - Death
- DT - Disqualifying Transfer
- I - Institutional Care
- M - Moved
- N - No longer eligible
- NM - No longer eligible for Medicaid
- NF - No longer functionally eligible
- T - Transferring to another region (complete section below)
- TPC - Transferred to Personal Care-State Medicaid Plan
- O - Other Specify: \_\_\_\_\_

### Transfer Case to Another Region Section

Client Name	ID Number	Date of Transfer	Receiving Region
Client's New Address			
Transfer/Start Date			

### PROVIDER TERMINATION

Please complete this section **ONLY** if the Provider is terminating their status as a QSP when the above client's case closes or is transferred.

Provider Name	Provider Number
Provider Name	Provider Number

**Forward to Developmental Disabilities within 3 working days.**