HCBS CASE CLOSURE/TRANSFER NOTICE/PROVIDER TERMINATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES/HOME AND COMMUNITY BASED SERVICES (HCBS)
SFN 474 (12-2018)

Clear Fields

Client Name	Client Identification Number (ND Number)
County Name	Case Manager

WAIVER REOPEN/CLOSE SECTION

ACTION TO BE TAKEN

☐ Re-open Current Screening

☐ Termination/Closure

Date Medicaid Waiver Services are to Begin
Date Medicaid Waiver Services are to End

CLOSURE/DENIAL SECTION

☐ SPED ☐ ExSPED ☐ Waiver

Date of Closure	Closure Code *

*** Closure Codes:**

B - Transferred to Basic Care
C - Client Discontinued/Refused Service
D - Death
DT - Disqualifying Transfer
I - Institutional Care
M - Moved
MW - Transferred to Medicaid Waiver
O - Other (specify): _____

N - No longer eligible
NM - No longer eligible for Medicaid
NF - No longer functionally eligible
EP - Transferred to ExSPED
S - Transferred to SPED
T - Transferring to another county (complete section below)
TPC - Transferred to Personal Care-State Medicaid Plan

TRANSER CASE TO ANOTHER COUNTY SECTION (used for SPED, ExSPED, waiver, MSP)

Client Name	Receiving County	Receiving Case Manager	
Client's New Address	City	State	ZIP Code
Date Client is Leaving Current County	Date Client is Entering New County		

PROVIDER TERMINATION

Complete this section **ONLY** if the provider is closing their status as a QSP (no longer working as a QSP) when the above client's case closes or is transferred.

Provider Name	Provider Number
Provider Name	Provider Number

Distribution: Original - Client's Case File **Copy** - Aging Services/HCBS (within three business days)