DD HCBS CASE CLOSURE/TRANSFER NOTICE

DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES DIVISION/HCBS
SFN 1008 (1-2014)

Clear Fields

Human Service Center Name	Developmental Disabilities Program Manager

Closure/Denial Section

Client Name (Last, First, Middle)	ID Number	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
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 Division within 3 working days.