DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

DISCHARGE/TERMINATION SUMMARY

Participant Name: DOB**:**

Funding Source: ☐ HCBS Child ☐ HCBS Adult ☐ CTS

Address: Phone #:

Type of discharge/termination:

☐ Participant initiated *(Check if Participant initiated discharge)*

☐ Community Support Provider initiated termination *(Check if CSP initiated termination)*

☐Case Manager initiated termination *(Check if CM initiated termination)*

Date of enrollment:

Date of discharge:

Name of Case Management Provider:

Name of Community Support Provider:

Contact Information (Guardian, parent or advocate who is familiar with ending of participant's services):
Name: Relationship:
Address: Phone:

Discontinuation at the request of:

Brief history of services prior to enrollment:

Summary of significant events during the period of service to the participant (What worked well, what should stay the same, what didn't work well, and what would you change):

Recommendations for future services **(ARSD 46:11:08:05:01)**. How was the participant, and/or participant's guardian, provided information regarding; 1) other services available in the community, 2) the funding impact and transfer options, and 3) other outcomes of service discontinuation:

Provider's evaluation of the appropriateness of the reason for ending services to participant:

Provider's recommendations for further assistance from the Division of Developmental Disabilities:

CSP Signature: _____ _____
Date

Case Manager Signature: _____ _____
Date

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Division of DD	**Date sent:**
Participant	**Date sent:**
Participant's guardian	**Date sent:**
Participant's advocate	**Date sent:**
Participant's parent, if minor	**Date sent:**
Participant's CSP	**Date sent:**
Participant's Case Manager	**Date sent:**