



State of Vermont
Agency of Human Services
Department of Disabilities, Aging and Independent Living
Business Office
103 South Main Street, Weeks Bldg.
Waterbury, VT 05671-1601

**Notification of Transfer or Termination of Home and
Community Based Developmental Disabilities Services**

Transfer: _____ Termination
(fill in **new** DA/SSA)

Consumer's Name: _____ Social Security #: _____

Current residence: _____ Unique ID#: _____

Initial waiver start date: _____ (column L on your spreadsheet)

DA/SSA: _____

Date home and community-based services were terminated/transferred _____

The **reason** for termination/transfer was _____

The budget amounts are as follows: Total budget _____

<u>Category</u>	<u>Frequency</u>	<u>Budget amount</u>
Service Planning & Coordination	_____	_____
Employment Services	_____	_____
Community Supports	_____	_____
Respite	_____	_____
Crisis-Individual	_____	_____
Clinical	_____	_____
Supported Assisted Living	_____	_____
Staffed/Group Living (circle one)	_____	_____
Home Provider	_____	_____
Transportation	_____	_____
Admin	_____	_____

If termination was not voluntary the consumer and his/her guardian, if applicable, must be notified of the right to appeal. Please attach a copy of written notification.

Signature of DA/SSA Representative

Date

Send to Joanne Herring @ DAIL and agency to which consumer is transferring.