VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
DEVELOPMENTAL DISABILITIES SERVICES DIVISION
280 STATE DRIVE HC2 SOUTH
WATERBURY, VT 05671-2030
PHONE: 802-241-0304 FAX: 802-241-0410

CLIN – DD HCBS (211HCBS-NTT)

Notification of Transfer or Termination of Developmental Disabilities Home and Community Based Services (HCBS)

☐ Transfer *(Fill in **New** Agency)*:_____ ☐ **OR** Termination

Consumer's name: _____ Social Security #: _____

Current residence: _____ Date of Birth: _____

Initial HCBS start date: _____ *(Column "L" on spreadsheet)* **Current Agency**:_____

Date terminated/transferred: _____ **Reason** for termination: _____

Budget amounts:

Category	**Frequency**	**Budget Amount**
Service Coordination		$
Employment Supports		$
Community Supports		$
Respite Supports (Hourly)		$
Respite Supports (Daily)		$
Clinical – Therapy		$
Clinical – Meds/Medical/Consult		$
Clinical – Assessment		$
Clinical – Other		$
Supportive Services		$
Crisis – Individual		$
Crisis – Local (Terminations only)		$
In-Home Family Support		$
Supervised Living (Hourly)		$
Staffed Living (Daily)		$
Group Living (Daily)		$
Shared Living (Daily)		$
Shared Living (Hourly)		$
Home Mod/Remote Supports		$
Transportation		$
Subtotal		**$**
Admin		**$**
	TOTAL BUDGET =	**$**

If the 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:**_____

Email form to: joanne.herring@vermont.gov or print and send via USPS to:
Joanne Herring, DAIL, 280 State Drive, Waterbury, VT 05671-2020
If it is a Transfer, also send a copy to the receiving agency.