Human Services Department

Wyandotte County Developmental
Disabilities Organization

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Service Termination Form

I, _____ have decided to terminate the following services.
Consumer's Name

	Medicaid	CFSS Grant
Day	☐	☐
Residential	☐	☐
In Home Family Supports	☐	
Direct Financial Supports		☐
Targeted Case Management	☐	

I am terminating these services for the following reasons:

☐ I no longer need or want the services checked above.
☐ The services are not meeting my needs. (Please Explain)

_____

_____

☐ I am moving out of State
☐ I am moving to another waiver or service setting (ex. ICF/MR).
☐ The above named person is deceased (Case manager, please sign form)

☐ Other: Describe: _____

I understand that my funding for the above services will not be available to me once I terminate the services. If I need the services in the future I will need to reapply and go onto the waiting list.

_____ _____
Signature of Consumer or Guardian Date

_____ _____
Signature of Case Manager Date