INDIVIDUALIZED SERVICES BUDGET
NOTIFICATION OF TERMINATION

1. Client Name: ____

2. Current Residence: ____
____

3. Medicaid Number: _____________________________________

4. Provider: ____

5. On__________________________ the Individualized Services Budget was terminated for the above-referenced individual.

6. The reason for termination was ____
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____
____
____

7. If termination was not voluntary, the service recipient and guardian must be notified of their right to appeal. Please attach a copy of the notification that was sent to the service recipient and his or her guardian.

____
Signature

____
Date