APPENDIX E

HOME AND COMMUNITY-BASED WAIVER
NOTIFICATION OF TERMINATION

1. Client Name: _____

2. Current Residence: _____
   Address
   _____
   City/State/Zip

3. Medicaid Number: _____

4. Provider: _____

5. On _____ Home and Community Based Waiver services were terminated for the above-referenced individual.
   Date

6. The reason for termination was: _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

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