ATTACHMENT 5

COUNTY MH/MR PROGRAM
NOTICE OF WAIVER SERVICE CHANGE/DISCONTINUANCE

NAME OF INDIVIDUAL:		
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	TELEPHONE NUMBER:
ADDRESS:		

Action: ☐ **Change** ☐ **Discontinuance**

Name of current waiver: ☐ **Consolidated** ☐ **Person/Family Directed**

☐ **Other (specify):** _____

Effective date of discontinuance of current waiver services: _____

Reason for discontinuance:

☐ **No longer eligible for ICF/MR level of care***

☐ **Exceeds cost limitation for waiver**

☐ **Waiver moved to another county** **Which county?** _____

☐ **Change to another waiver** **New County address** _____

☐ **Moved to another state**

☐ **Deceased**

☐ **Moved to nursing home or other long term care facility**

☐ **Chooses not to receive waiver funded services**

☐ **Other: Please specify** _____

If planning to change to another waiver, please specify change to:

☐ **Consolidated*** ☐ **Person/Family Directed*** ☐ **Other:** _____

***NOTE: Attach Form MR 250 or 251 if changing between Consolidated and Person/Family waivers.**
Attach Form MR 251 if discontinuance is based on ineligibility for ICF/MR level of care.

COUNTY MH/MR PROGRAM NAME	
CONTACT PERSON (PLEASE PRINT)	
TELEPHONE NUMBER OF CONTACT PERSON	DATE