

HCBS TBI WAIVER/WAITING LIST TERMINATION FORM

SECTION 1: CONSUMER INFORMATION

Name: _____

SSN: _____

Medicaid ID: _____

SECTION 2: TECHNICAL INFORMATION

Date Services Are To Be Terminated:

Reason For Termination Of Services:

Current TBI Waiver Consumer

(Please choose only one – most appropriate response)

- No longer Medicaid eligible
- No longer eligible for SSI/SSDI
- No longer meets LTC/Addendum score
- Being served by other waiver: _____
- No longer in need of TLS
- Permanent institutional placement
- Moved out of state
- Requests closure
- Death
- Other _____

TBI Waiver Waiting List Consumer

(Please choose only one – most appropriate response)

- Not Medicaid eligible
- Not eligible for SSI/SSDI
- No longer meets LTC/Addendum score
- Permanent NF placement
- Moved/cannot locate
- No longer requests services
- Death
- Other _____

SECTION 3: AGENCY INFORMATION

CIL/HHA : _____

TCM: _____

Additional
Information: