CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC LETTER OF TERMINATION

Member Name:_____ Recipient ID:_____

I have discussed my services with the clinician identified below and understand that the billing system reflects that I have been receiving services at another CCBHC agency. The clinician has made it clear that a Medicaid client can only be seen at a singular CCBHC agency at any given time. Signing this document affirms that I intend to discontinue services with my previous CCBHC agency and begin receiving services from_____.

My reason for ending services with the previous agency is as follows **(check all that apply):**

☐ Inconvenient location/hours

☐ Concerns about the quality of services received

☐ Does not have a good relationship with staff

☐ Unaware of other agency

☐ Provider doesn't offer all desired services

☐ Moved or new provider is closer or more convenient

☐ Declined to respond

☐ Other(fill in blank):_____

I understand that by signing this form I will be ending all of the services previously received at the previous CCBHC agency (including any medication services).

_____ _____
Member Signature (14 and over must sign) Date Signed

_____ _____
Legal Guardian Signature Date Signed

_____ _____
Print Name of LBHP, Credentials NPI

_____ _____
LBHP Signature Date Signed