NEW YORK STATE | Office for People With Developmental Disabilities

Self-Directed Service Termination/Transfer Form

This form is used as a communication and process coordination tool when Support Brokerage and/or Fiscal Intermediary (FI) services are terminating, changing, or transferring, and/or when a Participant is transferring between OPWDD Developmental Disabilities Regional Field Offices (DDRFO).

This form does **not** approve or deny services and does **not** by itself remove authorization of services from the participant's Self-Direction Budget or Life Plan.

The form is used to document notice, establish effective dates, and support coordinated action among the Participant/Representative, providers, Care Manager, and OPWDD.

Section I - Demographics		
Participant First Name:	**Participant Last Name:**	**TABS #:**
Mailing Address:		
Telephone:	**Email:**	

Name of Care Coordination Organization (CCO):	
Care Manager First Name:	**Care Manager Last Name:**
Telephone:	**Email:**

Name of Fiscal Intermediary Provider:	
Telephone:	**Email:**

Broker First Name:	**Broker Last Name:**	**Broker #:**
Telephone:	**Email:**	

Section II - Termination, Change or Transfer Being Requested	
Reason: ***(check all that apply)***	☐ **Self-Directed Services Plan Termination – Go to Section III**
	☐ **Fiscal Intermediary (FI) Termination – Go to Sections III and IV**
	☐ **Support Broker Termination – Go to Sections III and V**
	☐ **Inter-District/Inter-Regional Transfer – Go to Sections III, V and VI**

Section III - Reason(s) for Termination, Change, or Transfer
Please explain the reason for terminating, changing and/or transferring Self-Directed Services/Support Brokerage/Fiscal Intermediary services.

Section IV - New Fiscal Intermediary (if applicable)	
Name of Fiscal Intermediary Provider:	
Telephone:	**Email:**

Section V - New Support Broker (if applicable)		
Broker First Name:	**Broker Last Name:**	**Broker #:**
Telephone:	**Email:**	

Section VI - Inter-District and/or Inter-Regional Transfers (if applicable)
DDRFO the Participant is transferring from:
DDRFO the Participant is transferring to:

Signatures: (After signing, please submit form to the current DDRFO SPS.SD Mailbox.)	
By signing this document, I am acknowledging receipt of this form. My signature does not indicate that I am in agreement with the reason provided above.	
Person Completing Form:	
Participant/Representative Name and Signature:	**Date:**
Service Provider Signature: (required)	**Date:**

If the Participant/Representative signature is not obtainable, please explain why:

DDRFO Attestation (OPWDD Use Only)	
DDRFO Region Name:	
DDRFO Self-Direction Liaison:	
DDRFO Self-Direction Liaison Signature:	**Date:**