



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
<i>Please explain the reason for terminating, changing and/or transferring Self-Directed Services/Support Brokerage/Fiscal Intermediary services.</i>



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: