

Revised 8-17-10

**Termination/Denial of SCL Services Checklist**

**Provider Name:** \_\_\_\_\_ **Provider Number:** \_\_\_\_\_

**Person Completing Form:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_’s SCL services are terminated effective \_\_\_\_\_.  
(Formal letter must be mailed to Individual/Guardian and DMR/SCL services with 30-day notice to terminate).

\_\_\_\_\_’s request for SCL services is denied as of \_\_\_\_\_.  
(Send a copy of this form to individual, guardian or facility requesting services).

\_\_\_\_\_’s request for consideration of supports has been accepted.

**If services are being terminated or denied, please check all that apply:**

<b>Reason:</b>	<b>If yes, check <input type="checkbox"/></b>	<b>Comments:</b>
Aggression (A)		
Property Destruction (PD)		
Self-Injurious Behavior (SI)		
Disruption/ Non-compliance (D)		
Medical Condition (M)		
Physical Environmental Modifications required (PE)		
Inadequate Reimbursement Rates (R)		
Lack of Qualified/Specially Trained staff (QS)		
Level of Staff Supervision (LS)		
Behavior Plan/Functional Analysis needed (BP)		
Physical/Chemical Restraint used (PRN)		
Elopement Risk (E)		
Psychiatric Diagnosis (RX)		
Not Accepting New Referrals (NO)		
Do not provide residential supports (NR)		
Other, please specify (O)		

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**If you are denying supports, please identify the resources that would be necessary to successfully support this person in the community.**

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