State of Illinois
Department of Human Services -
Division of Developmental Disabilities

Service Termination Approval Request

Instructions: Use this Service Termination Approval Request (STAR) form to terminate Division of Developmental Disabilities - funded community, fee-for-service (FFS) programs and/or service packages identified on this form. Respite services, Individual Service and Support Advocacy (ISSA), or grant-funded services do not require termination approval.

ALL individual Division of Developmental Disabilities (DDD) service authorizations (including day programs, therapies and ISSA) will be terminated, even if your agency is not the provider, when the service package is terminated, *unless* an Application for Individual Service Authorization, or other notice in writing, requesting continuation of a specified service is attached to this form.

SECTION A - Individual and Provider Information

Individual's Name: Last _____ First: _____ M.I.: _____

Social Security Number: _____ Recipient I.D. Number: (RIN/E-RIN) _____

Provider Name: _____ FEIN: _____

DDD REGION: ☐ Northwest ☐ Central ☐ Metro-No. Suburbs ☐ Metro Chicago ☐ Northcentral ☐ South ☐ Metro-So. Suburbs

SECTION B - Program Termination

(Mark the program (s) that are being terminated with an "X")

		DAY SERVICES
X	PROGRAM CODE	PROGRAM DESCRIPTION
	31U	DEVELOPMENTAL TRAINING (DT)
	31A	DT (ADVANCE & RECONCILE)
	31S	DT FOR SODC
	38U	REGULAR WORK
	36G 36U 39G 39U	SUPPORTED EMPLOYMENT
	30U 35U 37U	OTHER DAY, ADULT DAY CARE, AND/OR AT-HOME DAY PROGRAMS

		RESIDENTIAL/SUPPORT SERVICES
X	PROGRAM CODE	PROGRAM DESCRIPTION
	17D	CHILDREN'S GROUP HOME
	19D	RESIDENTIAL SCHOOL/CHILD CARE INSTITUTION
	41D	SPECIAL HOME PLACEMENT
	42D	SUPPORTED LIVING ARRANGEMENT SLA
	60D	RATE MODEL COMM. INTEGRATED LIVING ARRANGEMENT (CILA)
	65H	HOURLY CILA
	67D/E/O	COMMUNITY LIVING FACILITY (CLF)
	68D	HOME/INDIVIDUAL PROGRAM (HIP)
	73D	RELATED SUPPORT
	CHBS	CHILDREN'S HOME-BASED SUPPORT SERVICES
	AHBS	ADULT HOME-BASED SUPPORT SERVICES

Requested Termination Date: _____

Last Date Present in the Residential Site: _____

For CILA (60D) Only: If the requested 60D termination date is after the last date present in the residential site, you must attach a DHS/DDD Bedhold Request form, even if there is less than 30 days difference between the two dates. DDD staff will adjust the 60D termination date to the last date present in the residential site if a complete Bedhold Request and documentation data are not attached to this STAR form in compliance with Division policy. If a bedhold request form is needed for this STAR, it must be completed and attached to this STAR at the time of the submission. Is it attached?

☐ Yes ☐ No (check one)

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Individual's Name: Last _____ First: _____ M.I.: _____

Social Security Number: _____ Recipient I.D. Number: _____
RIN/E-RIN

SECTION C - REASON FOR TERMINATION

(Check all that apply and enter the date of the event below)

Date of Death, Refusal, Transfer, or Move: _____

- ☐ Deceased
- ☐ Refused to continue DD -funded services (Check one or more) ☐ Residential ☐ Day Program ☐ Support Services
- ☐ Moved out-of-state
- ☐ Transferred to another program with the current provider New program code(s): _____
- ☐ Transferred to another provider New Provider Name: _____
- ☐ Admitted to a private ICFDD ICFDD Name: _____
- ☐ Admitted to an SODC SODC Name: _____
- ☐ Admitted to a nursing facility Facility Name: _____
- ☐ Incarcerated
- ☐ Other (specify): _____

Explanation:

SECTION D - Signatures

My signature below confirms that the individual and/or guardian/family have been notified of their appeal rights for the programs/ service package being terminated, and. if applicable, their appeal rights under the *Medicaid Home and Community-Based Services* waiver programs. I further confirm that the individual and/or guardian/family have chosen not to exercise or have exhausted their appeal rights. **I further confirm that if any services are to be continued, that an application or a written notice indicating the continuation of an existing service is attached. Is an application/notice attached?** ☐ Yes ☐ No

Provider Name	4 digit I.D. #:	Provider FEIN

Provider's Contact Signature	Date (Month/Day/Year)	Provider Contact's Telephone #	Extension

ISC Agency Name	4 digit I.D. #:	ISC Agency FEIN

ISC Contact Signature	Date (Month/Day/Year)	ISC Contact's Telephone #	Extension

DHS/DDD Signature (FOR STATE USE ONLY):
I have received this STAR form and approved this termination.

Region Facilitator Signature: _____ Signature Date: _____