Integrated Case Management Services
Termination Request

Agency: _____ Date: _____
Consumer's Name: _____ DOB: _____
Consumer's Address: _____
Date Enrolled: _____ Referral Source: _____
Primary Mental Health Diagnosis: _____

Termination is requested for the following reasons: (Check all that apply)

1. **Deceased**: (*Date*) _____
2. ☐ **Completion of Program:** ☐ 3 months ☐ 6 months ☐ 12+ months

Continued Treatment and Supportive Service {Psychiatrist, PH, Housing} Providers:

Agency/Contact: _____ Service: _____

Agency/Contact: _____ Service: _____

Agency/Contact: _____ Service: _____

3. **Discontinuation of Services:**

The following reasons (A to I) are for Program Termination (Select one)

A. ☐ *Consumer has demonstrated a sustained availability to function in areas of self-care, socialization, and work, without requiring assistance from ICMS program.*

B. ☐ *Psychiatric Hospitalization in New Jersey for three continuous months with no discharge date projected by the treatment team.*
Treating Hospital: _____ Date of Admission: _____

C. ☐ *Consumer is enrolled in another case management program which is a duplication of services (i.e., PACT, PATH, CSS).*
Agency: _____
Contact: _____ Phone: _____

D. ☐ *Incarceration in jail or prison for 90 days or more:* ☐ *State Prison or* ☐ *County Jail*

E. ☐ *Placement in a nursing home or similar institution with no projected discharge date.*
Nursing Home: _____ Date of Admission: _____

F. ☐ *Consumer requests discharge despite team's unsuccessful efforts to engage him/her/ and/or to develop a mutually agreed upon treatment plan. (List attempts made)*

G. ☐ *Unable to locate. (List attempts and efforts to engage)*

H. ☐ *Client transferred to:*
Agency: _____
Contact: _____ Phone: _____

I. ☐ *Client moved out of:* ☐ *State or* ☐ *County*

4. ***Refused ICMS Services (List Attempts)***
5. ***Does this individual have a DMHAS subsidy?*** ☐ *Yes or* ☐ *No*

6. ***Other:*** ***(Use only if information is not detailed above)***

<u>Use this space to provide the requested information in the Termination Guideline.</u>

Approvals {As required per county/region.}

Case Manager (Credentials) _____ Date: _____
Supervisor/Team Leader (Credentials) _____ Date: _____
Director (Credentials) _____ Date: _____