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|  | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  **Notice of Suspension of Supported Living Services** | | | | |
| AGENCY NAME | | | | | P1 NUMBER |
| PROVIDER’S CONTACT PERSON AND TITLE | | | | | PROVIDER’S PHONE NUMBER |
| **Client Information** | | | | | |
| CLIENT’S NAME | | | CLIENT’S ADSA ID NUMBER | CLIENT’S PHONE NUMBER | |
| LEGAL REPRESENTATIVE’S NAME (IF APPLICABLE) | | | LEGAL REPRESENTATIVE’S PHONE NUMBER | | |
| REGION | DATE OF SERVICE SUSPENSION | | DATE OF NOTICE TO CLIENT / LEGAL REPRESENTATIVE | | |
| **This notice indicates that the provider has temporarily suspended services to the identified client and is not responsible for the health, safety, and direct supports services assigned to the provider in the client’s Person Centered Service Plan (PCSP) and the Individual Instruction and Support Plan (IISP).** | | | | | |
| CIRCUMSTANCES LEADING TO SUSPENSION  Explain the circumstances that led to suspension of the client’s services. Explanation must include why actions or continued presence of the client endangers the health or safety of the client, other clients, those working with the client, or members of the public. | | | | | |
| CLIENT’S CURRENT LOCATION THAT CAN ADDRESS THEIR NEEDS  Describe any interim services that will be provided during suspension. | | | | | |
| PROVIDER’S SIGNATURE DATE | | | RECEIVED BY DDA DATE | | |
| **Provider Modification of Suspension** | | | | | |
| DATE OF SUSPENSE MODIFICATION | | DATE OF NOTICE TO CLIENT / LEGAL REPRESENTATIVE | | DATE OF NOTICE TO DDA | |
| DESCRIBE HOW THE SUSPENSION IS BEING MODIFIED  Explain any change to interim services or how the client’s condition has changed to allow their safe return to services. | | | | | |