W-1529
(Rev. 2/09)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

DISCONTINUANCE RECOMMENDATION FORM

TO: DSS Alternate Care Unit DATE:_____

Fax #: (860) 424-5313

FROM:_____

1. Client Name_____
2. Client EMS ID No._____
3. Discontinuance reason (codes at bottom of form):_____
4. Date of the event resulting in the discontinuance recommendation

   Death:____/___/____ Admission to LTC:___/___/____ Nursing Facility:_____

   Other:____/___/____
5. Date of Status Reviews: ____/___/___ ___/___/____

Comments:_____

_____

FOR DSS USE ONLY	REASON CODES
Discontinuance Date: ____/___/_____ Comments:_____ _____ _____ _____ _____ _____ Staff Signature Date	1. Died 2. Hospital stay exceeds program limits 3. Became financially ineligible (over income, over assets) 4. Became ineligible due to level of care 5. Care plan exceeded Social Service cost limit 6. Care plan exceeded total cost limit 7. Moved out of state 9. Entered LTC due to health 10. Entered LTC due to client choice 11. Non-compliance with contribution requirements (refused to sign, refused to pay) 12. Refused services 13. Lack of services 17. Other