**Termination Tracking Form**

**Subject: Termination for County/Contract Providers**

**Program** to complete as much information on this form as available and submit to QMS for review. Form is then submitted to IRIS to begin building program into the IRIS system – time is crucial! As more information is known, Program to submit updated tracking form with current date and only updated information that is being added/changed.

|  |  |
| --- | --- |
| **Today’s Date:** | Click or tap to enter a date. |
| **Provider Name *DHCS*** (60 characters max including spaces)**:** | Click here to enter text. |
| **Provider Name *IRIS*** (16 characters max including spaces)**:** | Click here to enter text. |
| **Address (include 9-digit zip code):** | Click here to enter text. |
|  | Click here to enter text. |
|  |  |
| **Phone #:** | Click here to enter text. |
| **Fax #:** | Click here to enter text. |
| **Legal Entity #** *(Corporate)***:** | Click here to enter text. |
| **Legal Entity Name *(Corporate Name)*:** | Click here to enter text. |
| **Provider #:** (QMS applies using PFU, approx. 1-2 month wait) | Click here to enter text. |
| **Provider NPI #:** | Click here to enter text. |
| **NPI # Deactivation Date** (Only Contract Providers)**:** | Click here to enter text. |
| **NPI # Deactivation notice attached** (Only Contract Providers)**:** | Yes  Pending |
| **Head of Service (HOS):** | Click here to enter text. |
| **Provider Contact Person Name (\*a person who can communicate with HCA):** | Click here to enter text. |
| **Provider Contact Phone # and email:** | Click here to enter text.  Click here to enter text. |
| **Reason for Termination of provider:** | Click here to enter text. |
| **Termination Date:**  **Last Date of Service:**  **Date Billing queues cleared:**  **Date all notes have been entered, all clients have been discharged and all EOCs have been Closed:** | **\*Date or TBD**    **\*Date or TBD**    **\*Date or TBD**    **\*Date or TBD** |
| **Please check types of Mental Health Service Activity to be terminated below.** | **List any updates to the services** |
| **05/40 Crisis Residential,** Number of Beds (maximum of 16)  **15/01 Case Management including 15/07 Intensive Care Coordination (ICC)**  **15/20 Peer Support Services**  **15/30 Mental Health Services including 15/57 Intensive Home-Based Services**  **15/58 Therapeutic Behavioral Services (TBS)**  **15/60 Medication Support;  Prescription-only  Medication Room**  **15/70 Crisis Intervention** | Click here to enter text.  Click here to enter text.  Click here to enter text.  Click here to enter text.  Click here to enter text.  Click here to enter text.  Click here to enter text. |