Kentucky CCBHC Demonstration
Designated Collaborating Organization (DCO)
Termination Request

CCBHC Information

CCBHC Agency Name: _____ Request Date: _____

CCBHC DCO Designated Lead: _____

CCBHC DCO Designated Lead Email: _____

DCO Information

DCO Agency Name: _____

DCO Address: _____ Phone: _____

DCO Primary Contact Name: _____ Email: _____

Contract Start Date: _____

Contract Termination Date: _____ Last date of service delivery: _____

Applicable DCO Medicaid provider number(s): _____

Service Information

List Service(s) currently provided by the DCO:

List CCBHC Service Code(s) used:

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Is termination of this agreement based on non-compliance with State or CCBHC criteria requirements? ☐ YES ☐ NO

Has the CCBHC developed a transition plan to ensure service continuity for all individuals served by the DCO and including how capacity of services provided by the DCO will continue at the CCBHC? ☐ YES ☐ NO

Please provide the rationale for termination of this DCO agreement.

Documents *(to be provided with this request)*:

Transition/Continuity of Service Plan