

Utah DHS/DSPD Form 2-9T	State of Utah: Department of Human Services Division of Services for People with Disabilities	_____ Region _____ Office
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Notice of Termination of FMS service

Date:

To: _____ (FMS Contractor)

This notice serves to notify you that, effective the last day of _____, 20__, your authorization to provide financial management services (FMS) for:

(Name of consumer)

(ID #)

will expire. Your authorization to submit additional billing for charges arising from the provision of FMS services to the above-referenced consumer expires on this same day. You are authorized and expected to process payment for any reasonable and approved obligations that you may be presented with for the above-referenced consumer up to fourteen (14) days after the expiration of your authorization as well as for such other obligations as may be authorized by the Regional Director. However, since your provision of services to pay these additional obligations will have already been compensated, you are NOT authorized to submit additional billings to DSPD or the consumer for processing these additional obligations.

Support Coordinator

Cc: Regional Director
Regional Contract Analyst
Regional ASM

INSTRUCTIONS: If the consumer has provided notice of their intent to transfer/terminate FMS services by the 15th of the month, enter the current month in the space above. If notice is provided AFTER the 15th, enter the FOLLOWING month.