Service Termination/Change

Community Counseling Services

Rev 01/17

Case Name _____

Case Id# _____

Date _____

□ Service Termination

□ Service Change **Effective Date of Service Change/Termination:** _____

Service Termination is expected to be ( ) Temporary ( ) Permanent

Reasons for Service Termination/ Change *(Check all that apply):*

( ) Change in Diagnosis ( ) Change in Symptoms
( ) Change in Service Activities ( ) Change in Treatment Recommendations
( ) Change in Service Staff ( ) Appropriate for Less Intensive Service
( ) Other _____

List Service(s) Discontinued

List Service(s) Initiated

Service Staff Change

From: **Billing Number**_____	**To:** **Billing Number**_____
(Staff name/credential)	*(Staff name/credential)*

Service Change Instructions or Information:

_____ _____
Signature/Credentials **Date**

_____ _____
Supervisor's Signature/Credentials *(if applicable)* **Date**