Self-Imposed Moratorium Form

Provider Agency Name: ____________________________  Contact Name: ____________________________

Provider #: ____________________________  Email: ____________________________

Phone #: ____________________________  Fax #: ____________________________

Add  Delete  DD  MF  Svc(s)  County(ies)

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Circumstances substantiating the need for a self-imposed moratorium:

□ Agency has lost key staff;

□ Temporary economic issues that impact the agency’s ability to accept new DD Waiver individuals;

□ Staff illness or physical disability affecting the ability of the agency staff to travel long distances;

□ Agency has accepted into service a large number of individuals within a short time frame;

□ Other (please describe):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

FOR DDSD USE ONLY:

This Request is:

□ Approved  □ Approved with conditions*  □ Denied

Effective Date:

End Date (if applicable):

Approved or Denied By:

*Approved with the following conditions:

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Please fax your request to the Provider Enrollment Unit at (505) 476-8894.

Revised 2.2015