Self-Imposed Moratorium Form

Provider Agency Name:_____ **Contact Name:**_____

Provider #:_____ **Email:** _____

Phone #: _____ **Fax #:** _____

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

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:**

	Region	Date Out	Date Returned	Approved	Denied	No Response	COMMENTS
___	METRO	_____	_____	_____	_____	_____	_____
___	NERO	_____	_____	_____	_____	_____	_____
___	NWRO	_____	_____	_____	_____	_____	_____
___	SERO	_____	_____	_____	_____	_____	_____
___	SWRO	_____	_____	_____	_____	_____	_____
___	BT	_____	_____	_____	_____	_____	_____
___	CM	_____	_____	_____	_____	_____	_____
___	CSB	_____	_____	_____	_____	_____	_____

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