**\*\*\*USE YOUR AGENCY LETTERHEAD\*\*\***

**Individual Name**

**Address**

**City, State, Zip Code**

Dear **(Insert Name),**

Thank you for letting **(insert agency name**) serve you through North Dakota’s 1915(i) Medicaid Home and Community-Based Services.

This letter is to let you know that (insert agency name) is no longer able to offer you our 1915(i) services. The reason for this decision is **(please state the reason for the discharge in simple terms: “We have not been able to contact you for X amount of time.” “We no longer have a provider in your area right now.” etc.)**

If you are working with a Care Coordinator right now, they will help you to find a new provider. If you have not been working with a Care Coordinator, please contact the State 1915(i) team at nd1915i@nd.gov or the 1915(i) Navigator at (701) 328-4850 for assistance.

We wish you the best on your continued recovery journey.

Sincerely,

**Signature**

**(type name of sender)**

**(insert agency name)**

**\*\*\* This letter should also be sent to the State 1915(i) team at** **nd1915i@nd.gov** **and to the person’s Care Coordinator by e-mail, unless this person has been sent to your agency for Care Coordination.\*\*\***