# New York State
# Office of Addiction Services and Supports

## Provider Termination Plan

Any provider of addiction services planning to terminate an OASAS certified service is required to complete and submit a copy the Termination Plan ***six months prior to the termination of services***. The Executive Director or Chief Executive Officer must sign and date the form and the plan must be submitted to the appropriate OASAS Regional Office and to Local Governmental Officials. Providers of an Opioid Treatment Service must also submit a copy to the OASAS Treatment Bureau within the Division of Practice Innovation Care Management. **Attach additional sheets, if necessary**.

| **Provider Identifying Information** | | | |
|---|---|---|---|
| **Provider Legal Name** | | | |
| **Contact Person/Title** | | **Telephone Number** | |
| **Service Site to Be Closed** | | | |
| **Service Name** | | | **OASAS OC # (last 5 digits)** |
| **Service Address** | | **City** | **Zip Code** |
| **County** | **Region** | **Provider No.** | **PRU #(s)** |

| **Termination Plan** |
|---|
| **1. Identify the final date services will be available (must be no less than six months after the date of this Termination Plan).** |
| **2. Provide a detailed explanation of the reason(s) for closing and efforts undertaken to avoid the closing.** |
| **3. Identify all local community contacts, referral sources and government agencies that have been notified of the impending service closing. (Providers of an Opioid Treatment Service must indicate how and when notifications were provided to CSAT and DEA).** |

## Transfer of Patients

**4. Complete the following:**

**a.** **Number of enrolled patients on the date of this Termination Plan**

**b.** **Number of enrolled patients expected to complete treatment before the proposed date of termination (as indicated in Item #1 of this Plan)**

**c.** **Number of currently enrolled patients to be transferred before or upon date of service termination**

**5. Providers must retain responsibility for the continued provision of patient care during the transition period prior to the Service closing. Describe plans to notify all patients in advance about the service closing and about their options for continued treatment (for providers of an Opioid Treatment Program, the notice must be given at least three months before closing).**

**6. Describe the process to be used in assessing the clinical needs of each patient prior to their referral or transfer to another certified provider. Describe plans to address the ongoing clinical needs (including continued methadone maintenance), any legal requirements (such as notifications to Probation or Parole Departments) or other treatment-related needs of all enrolled patients, as appropriate, prior to the Service closing.**

**7. List all OASAS-certified providers to which patients will be transferred. Include for each provider a contact person and telephone number. Attach documentation of each provider's agreement to cooperate in the transfer process.**

## Patient Consents and Disposition of Patient Records

**8. Describe the procedures to be used to obtain each patient's consent to transfer and to complete the transfer of such records.**

**9. Describe the procedures to be used to settle the patient financial accounts before completion of the transfer.**

**10. Describe plans for maintenance and/or disposition of patient records in conformance with Federal Regulations [42 CFR Part 2] regarding confidentiality. Attach a time schedule showing how the plan is going to be implemented. OASAS Regulation 14 NYCRR 800.5(d) requires all patient records must be retained for ten (10) years after the date of discharge or last contact, or three (3) years after the patient reaches the age of eighteen, whichever time period is longer.**

## Other Termination Plan Requirements

**11. a. If the Service is also certified by the Department of Health (DOH), has notification been provided?** ☐ **Yes** ☐ **No** ☐ **N/A**

**b. If yes, enter the date DOH was notified.**

**12. a. If the Service to be closed is an Opioid Treatment Program, has the CSAT and DEA been notified?** ☐ **Yes** ☐ **No**

**b. If yes, has the DEA Form 41 been filed:** ☐ **Yes** ☐ **No** **Date Filed**

**c. If medication is to be transferred or destroyed, indicate the steps that will be taken to meet all DEA requirements.**

**13. Other – Provide any additional information necessary to complete the termination of the Service, if applicable.**

| Provider Authorization to Terminate Services | | |
|---|---|---|
| **I certify that all information included or attached to this Termination Plan is accurate, complete and true to the best of my knowledge.** | | |
| **Executive Director (Full Name)** | **Executive Director Signature** | **Date** |
| **Board of Directors Chair/President (Full Name)** | **Board of Directors Chair/President Signature** | **Date** |

**Additional Requirements for OASAS-Certified and Funded Providers**

A provider supported in whole or in part with State funds administered by OASAS must also complete Appendix A – Provider Termination Plan Checklist, including the provider certification and signature block.