PROVIDER CLOSURE FORM

Colorado Department of Human Services
CCS-75B, Rev. 12/06

Provider I.D. #:

FOR CHANGE OF ADDRESS, ATTACH THE ISSUE CERTIFICATE FORM TO THIS FORM.

Provider type (select one): _____ **Foster Home** _____ **Foster/Adopt Home**

PRIMARY CARE PROVIDER:

_____
Last Name **First Name** **Middle Initial**

_____
Social Security #

SPOUSE'S NAME:

_____
Last Name **First Name** **Middle Initial**

_____
Social Security #

Location address that you are closing: **Telephone number:** _____

_____ _____ _____ _____ _____
Street Address **City** **State** **Zip Code** **County**

Name of Certifying Child Placement Agency: _____

License #: _____

Provider closure date: _____
(Month/Day/Year)

Reason for closure (select one):

- ☐ 01 Operator's request
- ☐ 02 Moved/reopening at new location
- ☐ 03 Employment
- ☐ 04 Medical/health
- ☐ 18 Child abuse/neglect
- ☐ 19 Divorce/separation
- ☐ 20 Consistent violation
- ☐ 21 Substance abuse
- ☐ 22 Emotional instability
- ☐ 23 Inadequate service provision
- ☐ 24 License/certificate expired –- no Notice of Renewal received
- ☐ 29 Opened in error
- ☐ 32 Insufficient financial resources
- ☐ 33 Insufficient interest/motivation for child care
- ☐ 34 Problems in relationship(s)
- ☐ 35 Unsuitable to provide child care
- ☐ 36 Certified by other agencies/out of county
- ☐ 37 Willful violation of regulations
- ☐ 38 Refusal of inspection/reports/records
- ☐ 39 Criminal record
- ☐ 41 Moved location (not reopening)
- ☐ 42 Agency decision
- ☐ 44 Adoption finalized
- ☐ 80 Provider applying for child care license
- ☐ 92 Death of provider

Date Foster Home gave notice to leave agency: _____
(Month/Day/Year)

Name of new agency: _____

Closure approved by:

_____ _____ _____ _____
Print Name **Signature** **Title** **Date**

AFTER COMPLETING THIS FORM, PLEASE REVIEW IT FOR ACCURACY BEFORE SUBMITTING IT TO OUR OFFICE! IF THE FORM IS INCOMPLETE OR INCORRECT, IT MAY BE RETURNED TO YOU!