*Letter of exit*

**Letterhead from Provider Agency including address, phone number, and email contact info**

Date _____

Dear _____:

Due to non-response to our letter dated (date) regarding continuation of services for (client name) and family, (client name) is exited from services and supports from (program) of (Provider agency).

Please note:

> You have the right to request a Fair Hearing to appeal your exit from these services. To request a hearing, you must submit a written request to:
>
> DPHHS, Office of Fair Hearings
> P.O. Box 202953
> Helena, Montana 59620-2953
>
> Your request must be received in the Office of Fair Hearings within 90 days after the date of this letter. You may represent yourself in the hearing process, or you may be represented by legal counsel, a relative, friend, or other spokesperson. If you have a disability, you may request reasonable accommodation in the hearing process by contacting the Hearing Officer.
>
> For information regarding Fair Hearings you may call the Office of Fair Hearings at (406) 444-2470. You may be eligible to receive free legal assistance from the Montana Legal Services Association. Their toll free number is 1 800-666-6124.

Should you have further questions, please contact (Family Support Specialist) or (Provider agency) at (phone number).

Sincerely,

(Family Support Specialist or administrative personnel)
(Provider agency)
(address)
(phone number)
(email address)

CC: (Client's name) file
(Regional office contact including title)