VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES
Individual Career Advancement Network (ICAN)

# ICAN PROVIDER DETERMINATION FORM

By submitting this form, your agency is indicating that the identified participant is not a good fit for the ICAN services and component your agency has enrolled them in and that there are no other components available within your agency that the participant is able to enroll in. The Provider Determination (PD) form is required to be sent via email, within 10 days of the decision, to AHS.DCFESDICAN@vermont.gov, The Subject Line must state Provider Determination.

As needed, please attach any documentation (e.g. incident reports, case notes, etc.) supporting your decision. PD instructions can be found in the ICAN Provider Handbook.

The participant will receive notification within 10 days of the receipt of this form, providing information on the PD process, their rights and how to contact the state agency if they would like to request a reassessment of their referral prior to their next recertification.

## PARTICIPANT'S INFORMATION

Participant's Name: ______________________________ Phone No.: ______________

Participant's Part ID: ______________________ Participant's Date of Birth: ______________

## PROVIDER'S DECISION

The participation has a provider determination due to the following:

Safety Concern.

Mental, physical, or legal limitation to participation.

Refusal to complete component or individual program requirements.

Ineligible for continued participation with a provider or individual program.

Other:

Recommend next steps based on assessment:

Are other ICAN providers included in this determination? Yes No
If yes, list providers:

Has the customer been informed of the determination by ICAN Staff? Yes No

## PROVIDER INFORMATION

Provider Agency: ______________ Phone No.: ______________ Email: ______________________

Staff Member (Name or Identifier): ______________________ PD Decision Date: ______________