

**Date:** [Current Date]

**To:** [Recipient Name/Patient Name]

[Recipient Address]

[City, State, Zip Code]

**Subject: Notice of Termination of Care Services**

Dear [Recipient Name],

This letter serves as formal notification that [Agency Name/Caregiver Name] will be terminating care services for [Patient Name] effective 30 days from the date of this letter.

The final date of service will be [Last Date of Service].

This decision has been made due to [Optional: Brief Reason, e.g., staffing changes, relocation, or violation of service agreement].

During this 30-day transition period, we will continue to provide care as scheduled. We recommend that you use this time to secure an alternative provider to ensure there is no lapse in care. We are available to provide a summary of care or transfer records to your new provider upon receipt of a signed authorization form.

If you have any questions regarding this transition or need assistance with the referral process, please contact [Contact Person Name] at [Phone Number] or [Email Address].

Thank you for the opportunity to have served you.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title/Organization Name]