Acknowledgement of Choice of Provider

Name: ______________________________ Date of Birth: ________________________

By signing this form, I acknowledge that a list of qualified Transitional Waiver Case Management (WCM) Services providers has been made available to me. I have chosen the provider listed below. I understand I may choose a different provider at any time.

Transitional WCM Services Provider: ____

____________________________________	____________________________________
Printed Name	Signature
____________________________________	____________________________________
Relationship to ICF/IID Resident	Date
____________________________________	____________________________________
Witness	Date