Acknowledgement of Choice of Provider

Name: _____ Date of Birth: _____

By signing this form, I acknowledge that a list of qualified Waiver Case Management 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.

Waiver Case Management Services Provider: _____

_____ _____
Printed Name Signature

_____ _____
Relationship to ICF/IID Resident Date

_____ _____
Witness Date