Acknowledge of Choice

Name: _____ Date of Birth: _____

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

Case Management Services Provider Name: _____

_____ _____
Printed Name Signature

_____ _____
Relationship to ICF/IID Resident Date

_____ _____
Witness Date

SAMPLE