BHRS FAMILY CHOICE NOTIFICATION FORM

I, _____, the parent/legal guardian of _____
(name) (child's name)

_____, have been made aware of the following services available to my child:
(DOB)

Please place a ✓ in the appropriate box for each service below:

Service	Already receive	Referral being made	Not appropriate
Family Based Mental Health Services			
Partial Hospitalization			
Outpatient Counseling			
Case Management (ICM, RC, Targeted/Blended)			

I realize that I may request a referral for any of the above services at any time by contacting my case manager

_____ _____
(name of case manager) (phone number)

I have also been made aware of alternative providers of BHRS/Wraparound services and am choosing

_____ as my provider at this time. I am aware that I can choose a new provider or new evaluator at
(provider name)

any time and that the above named provider or my case manager will assist me in making such a change at that time.

_____ _____
Client (if 14 years or older)/Parent/Legal Guardian Signature Date of Signature

_____ _____
Case Manager or County Representative Signature Date of Signature

_____ _____
Provider Representative Signature Date of Signature