RTF, IRT, TFC AND CRR FAMILY CHOICE NOTIFICATION

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			
BHRS/Wraparound			
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 enhanced behavioral health services and am choosing

________________________ as my provider at this time. I am aware that I can choose a new provider at any
(provider name)

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