PROVIDER SELECTION

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
TRAUMATIC BRAIN INJURY (TBI)

NOTE: This form must be returned to the Service Coordinator to complete Provider Selection process. Services may not begin until final notification by Service Coordinator is received.

I understand that as an applicant/participant for the above indicated waiver, I must select a Provider(s) from the attached list of approved Waiver Service Provider Agencies. I have been encouraged to interview the Provider(s) prior to making my selection. I understand that the Provider(s) will assist me with the development and implementation of a Detailed Plan which reflects my wishes and needs, maintains my health and welfare, and monitors the provision of services for quality and appropriateness.

I also understand that at any time I may change my Provider Agency and still be eligible for the waiver.

From the approved Provider Agency list, I have chosen:

Name of Provider Agency _____ Telephone _____

Provider Address _____

From this Provider agency, I am requesting the following services:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Applicant Signature _____ Date _____

Applicant's Address _____

Legal Guardian Signature (if applicable) _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

To be completed by Provider Agency:

Provider Agency

_____ will provide all of the above listed services
_____ is unable to provide the following service(s):

because: _____

_____ will not provide any of the above listed services

because: _____

Provider Contact Signature/Title _____ Date _____

Service Coordinator Signature _____ Date _____