GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT
OF BEHAVIORAL HEALTH

Mental Health Rehabilitation Services (MHRS) Core Service Agency
Consumer Choice Form Adult

The following MHRS Core Service Agencies have been identified as being available to enroll you. Please review the list carefully, ask questions, and make an informed decision as to which Core Service Agency you are choosing to provide your services.

Enrollment: _____

I, Our Community Support Services, LLC, by completing this form, am indicating my choice of the MHRS Core Service Agency in which I would like to receive services.

Transfer: _____

I am currently enrolled in a MHRS Core Service Agency and am requesting to transfer to a new MHRS Core Service Agency. My selection is noted below:

Current MHRS Core Service Agency: _____ **New MHRS Core Service Agency** _____.

Disenrollment: _____.

Reason for disenrollment: _____.

I am requesting to be disenrolled from services from _____.

By signing below, I assert that I have made this choice of my own free will and that there has been no pressure or coercion involved with me making this decision.

_____
Consumer's Name (Printed)

_____
Date

_____
Consumer's Address

_____
City/State/Zip Code

_____
Consumer's Phone Number

_____
Consumer's Date of Birth

_____
Consumer's Signature

_____
Consumer's Social Security Number

_____
Medicaid Number

For Provider Only:

I, _____, have witnessed the consumer declare which MHRS Core Service Agency they have elected to be enrolled without my encouragement, coercion, inducements and promises of services or transactions that are monetary nature.

_____
Initiating Supervising Clinician's NPI #:
Releasing

_____
Staff Initiating Transfer NPI#/Provider Signature/Role/Date

_____
Supervising Clinician's NPI #:

_____
Staff ***Releasing*** Transfer NPI#/Provider