Arkansas Department of Human Services
Division of Developmental Disabilities Services

Donaghey Plaza North
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Telephone (501) 682-8666 FAX (501) 682-8390

Choice Form

Name of Individual _____

I have been informed of all services available and would like to access the following choices.

SERVICES

___ Certified Case Management	___ Transportation
___ Occupational Therapy/Eval	___ Special Instruction
___ Physical Therapy/Eval	___ Home Based Parent Training
___ Speech Therapy/Eval	___ Evaluation
___ Developmental Day Treatment Clinic Svs.	___ Consultation
	___ 24 Hr. Residential/Institution
___ Respite	___ 24 Hr. Residential/Community
___ Supported Employment	___ Group Living/Community
___ Client Outreach Program	___ Supv. Apt. Living/Community
___ Case Management	___ Medicaid Waiver
___ Personal Care	___ Adaptive Equipment
___ Family Support	___ Other _____

I have been informed of all authorized providers for the service I have requested. I am choosing the following providers:

(Provider)	(Service)
(Provider)	(Service)
(Provider)	(Service)
(Provider)	(Service)

I understand that I have the option to change this choice at any time. I also understand that the chosen provider may elect not to provide services and that I may then chose another provider.

Individual/Parent/Guardian _____ Date _____

DDS Service Coordinator/Case Manager/ Program Staff _____ Date _____

Original: Master File
cc: Field File

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