

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

MHRS Core Service Agency _____

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: 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.

ICAMS #:

Provider Signature/Role/Date