Southwest Developmental Services, Inc.

"Helping Kansans with developmental disabilities access quality community services"

OPTIONS COUNSELING/CHOICE FORM

Name:_____ Address: _____

DOB:_____ City, State, Zip: _____

SS #:_____ Medicaid #: _____

MCO: _____ Telephone #: _____

INITIAL / CURRENT SERVICE(S):

☐ I would like to keep my services the same. However, I know that I have the option to make a change to my services at any time.

SERVICE:	SELECTED PROVIDER:
TCM	
DAY SERVICES	
RESIDENTIAL SERVICES	
PAS/FMS	

IF REQUESTING A CHANGE, PLEASE IDENTIFY CURRENT PROVIDER(S) AND NEW OR REQUESTED PROVIDER(S).

SERVICE:	CURRENT PROVIDER:	REQUESTED PROVIDER:
TCM		
DAY SERVICES		
RESIDENTIAL SERVICES		
PAS/FMS		

Notes:

By signing below, I am acknowledging that I have been presented all of my service options from the CDDO (SDSI) and that I am making an informed decision based upon the options that are available to me.

Name of consumer (Print): _____

Consumer/Guardian Signature (If Applicable): _____

Date: _____

CDDO Signature:_____

Effective Date:_____