

ACKNOWLEDGEMENT OF PROVIDER CHOICE

Consumer's Name: _____ MR No. _____

I understand that Southeastern Regional MH/DD/SAS is required to ensure that services provided are deemed medically necessary. I have been informed of my right to choose a provider from a list of service providers. I have been additionally informed of my right to change providers at a later date in my treatment.

_____ I, and I alone, have made this choice. My decision was not influenced by personnel from the Area Program/LME. _____
Name of Chosen Contract Provider

_____ My choice was denied and I understand that I can file a grievance with the Area Program/LME.

_____ Emergency choice made _____ (date) _____

Southeastern Regional MH/DD/SAS' explanation for denial/emergency choice:

Consumer or Legally Guardian Responsible Person

Date

Witness

Date