

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

FREEDOM OF CHOICE FORM

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

CHILD'S NAME, (LAST, FIRST, MI.):			
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:	DATE OF INTERVIEW:

I have been informed that I may be eligible for services provided through either the B2H Medicaid Waiver Program or a medical institution.

I have chosen to (Check one only):

- Apply for the B2H Serious Emotional Disturbance (SED) Medicaid Waiver.
- Apply for the B2H Developmental Disabilities (DD) Medicaid Waiver.
- Apply for the B2H Medically Fragile (Med F) Medicaid Waiver.
- NOT** apply for services through the B2H Medicaid Waiver Program at this time.

MEDICAL CONSENTER NAME:	MEDICAL CONSENTER SIGNATURE: X	DATE:
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HEALTH CARE INTEGRATION AGENCY REPRESENTATIVE NAME:	HEALTH CARE INTEGRATION AGENCY REPRESENTATIVE SIGNATURE: X	DATE:
NAME OF HEALTH CARE INTEGRATION AGENCY:		