SECONDARY FREEDOM OF CHOICE
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
Customized Community Supports - Group Service
BERNALILLO COUNTY

Date: 05/15/2024

DD Waiver Participant Name: _____

Dear Waiver Participant,

The Center for Medicare and Medicaid Services require that all waiver participants be afforded the right to select and obtain services from qualified providers approved by the Developmental Disabilities Supports Division (DDSD) for Home and Community Based Waivers. **Customized Community Supports - Group** Services, in **BERNALILLO** County, are available to you through the following:

_____	ADID Care INC	(505) 296-3684
_____	Community Options, Inc.	(575) 373-7259
_____	Cornucopia Adult and Family Services, Inc.	(505) 877-1310
_____	The New Beginnings, LLC	(505) 797-3359
_____	The Tungland Company LLC	(505) 717-1375

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This form needs to be signed and dated by the Waiver Participant or Legal Representative.

DD Waiver Participant Name: _____

I have selected the named provider below based on a review of all qualified providers listed on the Secondary Freedom of Choice approved by DDSD to provide **Customized Community Supports - Group** Services, in **BERNALILLO** County.

Name of Selected Provider: _____

_____ _____
Waiver Participant Signature Date Legal Representative Signature Date

_____ _____
Waiver Participant Printed Name Legal Representative Printed Name

_____ _____
Last Four Digits of Waiver Participant Social Security Number Legal Representative Telephone Number

_____
Waiver Participant Address

_____
City, State, Zip