SECONDARY FREEDOM OF CHOICE
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
Speech Therapy 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. **Speech Therapy** Services, in **BERNALILLO** County, are available to you through the following:

_____	Autism Specialists LLC	(505) 720-7537
_____	Desert Rose Speech Therapy LLC	(505) 306-8100
_____	Laurie Ross-Brennan & Associates, P.A.	(505) 268-5933
_____	Pediatric Therapy Inc.	(505) 620-0541

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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 **Speech Therapy** 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