ALBERTA PROFESSIONAL SERVICES, INC.

DECISION TO ENTER CARE/RECEIVE SERVICES/PROVIDER CHOICE

Name: _____Record No: _____

Medicaid #: _____DOB: _____

Date of Admission: _____

This serves as formal notification that I have selected Alberta Professional Services, Inc. as my service provider. I understand that I have the right to request a list of provider agencies in my area if I want to change providers. This is to be effective immediately.

I am aware that the final decision to enter care or receive services is mine, and my signature below indicates that I have made this decision.

_____
Signature of Individual or Legal Guardian (if appropriate) and Date

_____
Agency Representative and Date

This form meets these standards
Authority: NC Innovations Manual – Free Choice of Providers p.93