



Chester County Intermediate Unit

Student Services Division – Assessment & Clinical Services

HOME AND COMMUNITY SERVICES

BHRS FAMILY CHOICE NOTIFICATION FORM

I, _____, the parent/legal guardian of _____
(name) (child's name)

_____, have been made aware of the following services available to my child:
(DOB)

<u>Service</u>	<u>Already receive</u>	<u>Referral being made</u>	<u>Not appropriate</u>
Family Based Mental Health Service	_____	_____	_____
Intensive Care Management	_____	_____	_____
Outpatient Counseling	_____	_____	_____
Partial Hospitalization	_____	_____	_____

I realize that I may request a referral for any of the above services at any time by contacting my case manager

(name of case manager)

(phone number)

I have also been made aware of alternative providers of enhanced behavioral health services and am choosing

_____ as my provider at this time. I am aware that I can choose a new provider at any
(provider name)

time and that the above name provider or my case manager will assist me in making such a change at that time.

Client (if 14 years or older)/Parent/Legal Guardian Signature

Date of Signature

Case Manager Signature

Date of Signature

Provider Representative Signature

Date of Signature