

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT  
OF BEHAVIORAL HEALTH



**Mental Health Rehabilitation Services (MHRS) Core Service Agency  
Consumer Choice Form Adult**

The following MHRS Core Service Agencies have been identified as being available to enroll you. Please review the list carefully, ask questions, and make an informed decision as to which Core Service Agency you are choosing to provide your services.

**Enrollment:**

I, \_\_\_\_\_ by completing this form, am indicating my choice of the MHRS Core Service Agency in which I would like to receive services.

**MHRS Core Service Agency** \_\_\_\_\_

**Transfer:** I am currently enrolled in a MHRS Core Service Agency and am requesting to transfer to a new MHRS Core Service Agency. My selection is noted below:

**Current MHRS Core Service Agency:** \_\_\_\_\_ **New MHRS Core Service Agency** \_\_\_\_\_

**Disenrollment:** I am requesting to be disenrolled from services from \_\_\_\_\_.

**Reason for disenrollment:** \_\_\_\_\_.

By signing below, I assert that I have made this choice of my own free will and that there has been no pressure or coercion involved with me making this decision.

\_\_\_\_\_  
Consumer's Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Consumer's Address

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Consumer's Phone Number

\_\_\_\_\_  
Consumer's Date of Birth

\_\_\_\_\_  
Consumer's Signature

\_\_\_\_\_  
Consumer's Social Security Number

\_\_\_\_\_  
Medicaid Number

**For Provider Only:**

I, \_\_\_\_\_, have witnessed the consumer declare which MHRS Core Service Agency they have elected to be enrolled without my encouragement, coercion, inducements and promises of services or transactions that are monetary nature.

\_\_\_\_\_  
Supervising Clinician's NPI #:

\_\_\_\_\_  
Staff Initiating Transfer's NPI#/Provider Signature/Role/Date