**Division of Child and Family Services**

**Children’s Mental Health**

**Freedom of Choice Form**

I acknowledge I have been informed that my child may meet eligibility criteria to receive Medicaid covered children’s mental health services.

I acknowledge I have been informed that I have a choice to receive Medicaid covered children’s mental health services from any qualified Medicaid provider who agrees to provide these services.

By checking the relevant boxes below, I acknowledge I am choosing DCFS to provide Medicaid covered services to my child when these services are determined to be medically necessary.

Targeted Case Management Services

Individual, Family, and Group Therapy Services

Behavioral Health Screenings

Assessment

Psychiatric Services

Residential Program Services

Rehabilitative Mental Health Services

Psychological Testing

Pharmacy Services

Parent Training Services

Mobile Crisis Services

I acknowledge that if my child has been determined eligible for Targeted Case Management Services and I decline these services or if I choose a qualified non-DCFS Targeted Case Manager, this will not restrict my child’s access now or in the future to other DCFS services if these services are medically necessary and if my child is eligible to receive these services.

I acknowledge I have been informed that I may change my choice of provider at any time without penalty.

By signing below, I am acknowledging that I have made this choice of provider free of coercion or duress.

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Signature of Legally Responsible Person Date

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Signature of DCFS Staff Witness Date