TEXAS Health and Human Services

*Home and Community-Based Services*
*Adult Mental Health*

**Home and Community Based Services-Adult Mental Health (HCBS-AMH)**
**Provider Selection Form**

| | |
|---|---|
| **Form Type (check one):** ☐ **Initial** ☐ **Transfer** | |
| **Individual Name (last, first, mi):** Click here to enter text. | |
| **CARE ID Number:** Click here to enter text. | **CMBHS ID:** Click here to enter text. |
| **Address (street, city, state, zip):** Click here to enter text. | |
| **Date of Birth:** Click here to enter text. | |
| **Legally Authorized Representative Name, if applicable: (last, first, mi)** Click here to enter text. | |

**To be completed by the HCBS-AMH individual and/or the LAR:**

I have received a list of Home and Community Based Services-Adult Mental Health (HCBS-AMH) Recovery Management Entities(RM) and Provider Agencies(PA) that serve my community.

I am aware that I have the freedom to choose the person who provides Recovery Management and my HCBS-AMH Provider Agency services.

I have selected _____Click here to enter text._____ as my Recovery Management Entity and _____Click here to enter text._____ as my HCBS-AMH Provider Agency for the Home and Community Based Services-Adult Mental Health program.

I understand that once enrolled, I may transfer to another Recovery Management Entity or HCBS-AMH Provider Agency if I so choose. If I wish to change my Recovery Management or HCBS-AMH Provider Agency, I will follow the procedures as outlined in the Participant Handbook.

Point of Contact at referring entity (State Hospital/LMHA/LBHA) for PA and RM to contact for coordination of HCBS-AMH services:
Name: _____ Phone Number: _____
Email: _____

_____ _____
Signature & Date – Individual Signature & Date – LAR (If applicable)

***For Internal Use Only***

_____ _____
**HCBS-AMH Representative** **Date**