

List of Service Providers

Client's Name:

County:

Date:

Adult Day Care:

Homemaker:

Home Health Aide:

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In Home Respite:

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Institutional Respite:

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I certify by signing this form that I was given freedom of choice in selecting my service providers and that I was able to assist in the development of my plan of care

Signature of Client:	Date:
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Signature of Employee:	Date:
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